

**RESTORING TRUST: THE VIEW OF THE
ACTING SECRETARY AND THE VET-
ERANS COMMUNITY**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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RESTORING TRUST: THE VIEW OF THE ACTING SECRETARY AND THE VETERANS COMMUNITY

Thursday, July 24, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 9:32 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Flores, Denham, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, O'Rourke, and Walz.

Also present: Representative Fitzpatrick.

OPENING STATEMENT OF CHAIRMAN, JEFF MILLER

The CHAIRMAN. Good morning. I want to welcome everybody to today's oversight hearing entitled Restoring Trust.

I want to ask unanimous consent also that Representative Michael Fitzpatrick from the State of Pennsylvania be allowed to join us at the dais today and participate in this morning's hearing. Without objection, so ordered.

The committee is going to examine this morning what steps we need to take to help the Department of Veterans Affairs to get back on track to meet its core mission, a mission to provide quality health care to our veterans.

Since the beginning of June, this committee has held almost a dozen full committee oversight hearings. Some of them, as you well know, have gone way into the night and some into the early morning hours.

We want to do a top-to-bottom review of VA and to delve into how we are now situated in a crisis at the Department of Veterans Affairs. And while I hope to focus on the major themes we have covered and to receive updates from VA this morning on the topics that we have talked about over the last few weeks, I can promise the department and the committee Members here that, as we move forward to help mend the broken VA system, the oversight done by this committee is going to continue.

Mr. Secretary, in your written statement, you state that the status quo and our working relationship must change and that the department will continue to work openly with Congress and provide information in a timely manner.

First I agree that the relationship between VA and this committee must change. We must go back to the way business used to

be handled for decades when Members and staff could communicate directly with VA senior leaders about routine business we conduct with the department.

But using the phrase continue to work openly is in my opinion not a reflection of the current reality that we find ourselves in. Members of this committee, other Members of Congress and our staffs are still being stonewalled to this day and you will hear several questions that relate to that information.

For example, the day after our July 14th VBA hearing, our colleague, Mr. Jolly, personally spoke to Kerrie Witty, the director of the St. Petersburg Regional Office and asked for information regarding the firing of Mr. Javier Soto, a whistleblower who testified at that hearing.

Mr. Soto had raised very serious concerns about both retaliatory action and mismanagement at the St. Pete RO. And it is incumbent upon this committee to investigate those allegations.

But instead of being open and honest about the process, about Mr. Soto's removal, VA has equivocated, stonewalled, changed its story, and obstructed Members of this committee in what appears to be an attempt to cover up, VA's retaliation against Mr. Soto.

We are prepared to subpoena the documents if that is what it takes. We have got to get compliance with the multiple requests that we have made to the department.

I could not agree with you more that the department needs to earn back the trust of veterans, their families, the veteran service organizations, Members of Congress, and the American people through deliberate, decisive, and truthful action.

The recent scandals that have tarnished trust in the VA are a reflection of a broken system that didn't just happen overnight, nor can it be fixed overnight.

Upon stepping up as the acting secretary, you have stated that there has to be change and there has to be accountability, but I have yet to see where the department has drawn the line and brought those people who have caused this crisis to justice.

We have shown through many of our hearings that one contributing factor to the current crisis is that VA has clearly lost sight of its core mission and that extra funding didn't go to improvements in patient care but towards ancillary pet projects and an ever-growing bureaucracy.

According to an article by former under secretary of Health, Dr. Ken Kizer, in the New England Journal of Medicine, VHA's central office staff has grown from about 800 in the late 1990s to nearly 11,000 in 2012. This further illustrates VA's shift of focus to building a bureaucracy as opposed to fulfilling its duty to providing quality patient care.

And as I said before, the problems that exist today will not be fixed overnight and it cannot be fixed by simply throwing money at those problems. To date, the VA has been given every resource requested by the Administration. Every year during our budget oversight hearings, Members of this committee and Dr. Roe in particular has asked if the secretary had enough to do his job and every time we as a committee were told unequivocally yes.

This is why last week the acting secretary said that an additional \$17.6 billion was needed to ensure that VA is available to

deliver high-quality and timely health care to our veterans and when he did that, it raised some very obvious questions. Where did the number come from? What assumptions underlie this request and how were they made? What effort was made to look within existing resources at the department to meet these new sources or resource needs?

I know many of my colleagues would agree that after multiple oversight hearings, outside investigations, countless accounts being made by whistleblowers, VA's numbers simply cannot be trusted.

VA's determination that 10,000 additional medical staff is needed is also surprising when the secretary's own written statement states, and I quote, "VA doesn't have the refined capacity to accurately quantify its staffing requirements," end quote.

If they don't have the ability to accurately predict staffing needs, then how do we know that 10,000 more bodies is what is needed to solve the problem?

I would also remind Members that we don't have any type of grasp on how the department is going to spend the new funding that they have requested. The President's 2015 budget request, 1,300 pages. You have all seen it. It is in your office, 1,300 pages.

The request from the department, the first request from the department I had been saying was a three-page request and that request actually is a single page. This is all we got. I hope all of you got a copy of this because this is how they, in fact, justified their request.

And I asked the secretary on the telephone early this week if he would delve into and give us a more complete review of what they requested and I was told that we would get a much more detailed request. We got two pages. That is all we got, two pages entitled Working Estimate as of July 22nd of 2014 for \$17.6 billion.

Now, yes, the number has been refined to about \$13 and a half billion now, but, still, two pages for \$13 and a half billion? Our veterans deserve the best, but throwing money at the department into a system that has never been denied a dime will not automatically fix the perverse culture that has encompassed the department.

VA can no longer consider itself the sacred cow that is not subject to rules of good government and ethical behavior. Veterans are sacred. VA is not. Ultimately we are talking about a system that has a long road ahead of it before it can get back to an organization deserving of our veterans and the sacrifices that they have made.

I hope that today we receive the needed insight from our veteran service organizations. They and their members are on the ground. They need to be partners as VA tries to rebuild the trust that is lost. I hope that together we can bring about true change to this broken system and a change that will fix the corrosive culture that has encompassed the Department of Veterans Affairs for far too long.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

With that, I yield to the ranking member for his opening statement.

**OPENING STATEMENT OF MICHAEL MICHAUD, RANKING
MINORITY MEMBER**

Mr. MICHAUD. Thank you very much, Mr. Chairman, and good morning.

I want to thank you, Mr. Chairman, for holding today's hearing and for leading our rigorous oversight over these past few months. It has been a long road getting here. The hearings that we have held over the past few months have yielded difficult, disturbing, but ultimately important information.

With each hearing, we have heard of a different aspect of the Department of Veterans Affairs that just isn't working. We heard about some challenges like the claims backlog and technology issues which we have been confronting for quite some time now. We learned of others like how the VA treats whistleblowers and the reality of the data VA reports and new ones.

The VA has a good product. When veterans get to see a VA doctor, they like the care that they get. When veterans get the eligibility rating and starts receiving VA benefits, they find those benefits to be useful and helpful.

But the business model for producing and delivering and supporting the VA product is fundamentally broken. We have heard this time again over the course of these hearings. There is a clear cultural problem at the Department of Veterans Administration. There are scheduling failures and technology problems. Inconsistent office practices lead to backlogs that appear to be tackled at the expense of other services.

The Department of Veterans Administration is a sprawling agency that offers critical services to millions of our veterans. It is clear to me that we need a business-minded approach to reform the agency. More of the same isn't going to solve the underlying problems. Tweaks and band-aids around the margins aren't going to sustain the system.

We need a new model, a new approach, and a new way of thinking about and looking at the department. We need immediate short-term fixes, but we also need a long-term vision and a new approach to the business of the Department of Veterans Administration.

And I would like to thank you, Secretary Gibson, for joining us today and for your efforts over the last few months. You have stepped up to the plate at the most challenging moments in the Department of Veterans Affairs' history and you owned the problem of the organization that has been experienced over the last several years.

And I thank you for your increased effort to communicate with us on The Hill, for your dedication to our Nation's veterans, and for exhibiting the courage to be the face of the Department of Veterans Administration during these very difficult times.

I would also like to similarly thank Bob McDonald who I hope will soon be confirmed as the next VA secretary. I am looking forward to talking with Mr. McDonald about his vision for reforming the Department of Veterans Administration both in the short term as well as in the long term.

Like Mr. Gibson, Mr. McDonald is exhibiting extraordinary courage and commitment for taking on this role at this very important time.

I would also like to thank the veteran service organizations for joining us today. You have been strong and relentless advocates for the well-being of our veterans. You have done an excellent job in holding all of us in Congress and the department accountable. You are a key stakeholder in this whole debate over the Department of Veterans Affairs. You need to be active, engaged in the process of long-term reforms for the Department of Veterans Administration.

So I want to thank all the VSOs as well for your continued effort that you have been doing and keeping an eye on what is happening with the department and for joining us today.

So, once again, Mr. Chairman, I want to thank you for having this very important hearing. With that, I yield back the balance of my time.

[THE PREPARED STATEMENT OF HON. MICHAEL MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to my good friend, Mr. Michaud.

Before we begin this morning, I want to recognize some participants that are in the audience with us from The American Legion Boys Nation who joined us here today. Welcome to all of you and thanks for being here. We are glad to have you with us.

This morning, we are going to hear from the Honorable Sloan Gibson, acting secretary for the Department of Veterans Affairs. And to you, sir, we owe a great debt of gratitude for stepping in as number two and then stepping up, as my ranking member has said, during a very trying time for the department. And we appreciate you being here.

He is accompanied by Mr. Danny Pummill, deputy under secretary for Benefits at the Department of Veterans Affairs, and Philip Matkovsky, assistant director under secretary for Health and Administrative Operations at the Department of Veterans Affairs.

And as always, your complete written statement, Mr. Secretary, will be made a part of the hearing record. And with that, you are recognized for your opening statement.

STATEMENT OF SLOAN D. GIBSON, ACTING SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DANNY PUMMILL, PRINCIPAL DEPUTY UNDER SECRETARY FOR BENEFITS, VETERANS BENEFIT ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; PHILIP MATKOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATIVE OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF SLOAN D. GIBSON

Mr. GIBSON. Thank you, Mr. Chairman.

I will get straight to business. Concerning VA health care, we have serious issues. Here is how I see the problems.

First, veterans are waiting too long for care. Second, scheduling improprieties were widespread including deliberate acts to falsify

scheduling data. Third, an environment exists where many staff members are afraid to raise concerns for fear of retaliation. Fourth, metrics became the focal point for some staff instead of focusing on the veterans we are here to serve. Fifth, VA has failed to hold people accountable for wrongdoing and negligence. And, last, we lack sufficient resources to meet the current demand for timely, high-quality health care.

As a consequence of these failures, the trust of the veterans we serve, the American people, and their elected representatives has eroded. We have to earn that trust back through decisive action and by greater transparency in dealing with all of our stakeholders.

To begin restoring trust, we have focused on six key priorities. Get veterans off wait lists and into clinics; fix systemic scheduling problems; ensure that veterans are the focus of all we do. In a culture where leaders ensure accountability, where transparency is the norm, and where employees live, our VA values every day.

Hold people accountable where willful misconduct or management negligence are documented; establish regular and ongoing disclosures of information; and, finally, quantify the resources needed to consistently deliver timely, high-quality health care.

Here is what we are doing now. VHA has reached out to over 173,000 veterans to get them off wait lists and into clinics. We are adding more clinic hours, recruiting to fill clinical staff vacancies, deploying mobile medical units using temporary staffing resources, and expanding the use of private sector care.

In the last two months between mid May to mid July, we have made over 570,000 referrals for veterans to receive care in the private sector. That is up more than 107,000 over the comparable period a year ago. Each of those referrals will on average result in seven actual appointments and visits. So that produces an increase of more than 700,000 appointments and visits for care in the community above last year just associated with the increase in referrals over a two-month period.

VHA is posting regular twice monthly data updates to keep veterans informed about progress we are making in access. As part of the effort to improve transparency, I recognize, Mr. Chairman, that we have more work to do in providing complete and timely responses to congressional inquiries and requests. You all are keeping us very busy in that regard right now.

We are moving to improve our existing scheduling system and simultaneously pursuing the purchase of a modern commercial off-the-shelf system. I have directed medical center and VISN directors to conduct monthly in-person inspections of their clinics to assess scheduling practices and identify any related obstacles to timely care for veterans. To date, over 1,500 of these visits have been completed.

We are putting in place a comprehensive external audit of scheduling practices across VHA and we are building a more robust system for measuring patient satisfaction. I have personally visited 13 VA medical centers in the last six weeks to hear directly from the field how we are getting veterans off wait lists and into clinics.

The 14-day access measure has been removed from over 13,000 individual performance plans. For willful misconduct, management

negligence, or whistleblower retaliation is documented, appropriate personnel actions will be taken.

I have frozen VHA's central office and VISN headquarters hiring. VHA has dispatched teams to provide direct assistance to facilities requiring the most improvement including a large team on the ground in Phoenix right now. In addition, we have taken action on all of the recommendations made in the IG's May interim report on Phoenix.

All VHA senior executive performance awards for fiscal year 2014 have been suspended. Additionally, I have directed a fundamental revision of all medical center and VISN directors' performance objectives to ensure they are aligned with patient outcomes.

I have repeatedly taken a firm stand on the subject of whistleblower retaliation. In messages to the entire workforce and in numerous face-to-face meetings with employees and leaders, I have made it clear that we will not tolerate retaliation against whistleblowers.

Furthermore, I committed to Carolyn Lerner when I met with her several weeks ago that we will achieve compliance with the Office of Special Counsel certification program, and she and I have agreed to streamline the process by which we work together to ensure appropriate whistleblower protection.

We have also established internal processes to ensure appropriate personnel actions are taken where retaliation has been documented. I have made a number of leadership changes including naming Dr. Carolyn Clancy interim under secretary for Health. New to VA, she is spearheading our immediate efforts to accelerate veterans' access to care.

Dr. Jonathan Perlin has begun his short-term assignment as senior advisor to the secretary. Dr. Perlin comes to us on loan from the Hospital Corporation of America where he is the chief medical officer and the president of clinical services. He is also chairman elect of the American Hospital Association. Dr. Perlin brings a wealth of knowledge and experience to help us bridge the period until we have a confirmed new under secretary for Health, a position Dr. Perlin himself once held.

As part of the restructure of VHA's Office of the Medical Inspector, we call that OMI internally, Dr. Jerry Cox has been appointed to serve as interim director. A career naval medical officer and a former assistant inspector general of the navy for medical matters, Dr. Cox will help ensure OMI provides a strong internal audit function, helping to ensure the highest standards of care quality and patient safety.

As we complete reviews and investigations, we are beginning to initiate personnel actions to hold those accountable who committed wrongdoing or were negligent. To support this critical work, Ms. Lee Bradley has begun a four-month assignment as special counsel to the secretary. Ms. Bradley is former general counsel at VA and most recently a senior member of the general counsel team at the Department of Defense where she has direct responsibility for their ethics portfolio.

Shifting gears, in the area of resources, I believe that the greatest risk to veterans over the intermediate to long term is that additional resources are provided only to support increased purchases

of care in the community and not to materially remedy the shortfall in internal VA capacity. Such an outcome would leave VA even more poorly positioned to meet future demand.

Today VA's clinical staff and space capacity are strained. Between 2009 and 2013, the number of unique veterans we treat annually has increased by over a half a million. And the typical veteran we treat today has on average nine major diagnoses.

In just the last three years, 40 veterans' health care facilities have experienced double digit growth in the number of patients who come through their doors. As an example, at the Fayetteville, North Carolina VA Medical Center which I visited several weeks ago, the number of patients being treated has grown 22 percent in the last three years.

Resources required to meet current demand covering the remainder of fiscal year 2014 through fiscal year 2017 total over \$17 billion. While the amount is large, it represents a moderate percentage increase in annual expenditures. These funds would address clinical staff, space, information technology, and information technology necessary to provide timely, high-quality care.

Let me briefly address benefits. Since arriving at VA, I have been very impressed with VBA's ongoing transformation. I doubt that any major part of the Federal Government has transformed so much in the past two to three years. And I believe that because of this transformation, we are on track to eliminate the disability claims backlog in 2015.

Having said that, veterans still wait too long to have their claims decided and our quality is still not up to our own standard. A portion of our request for additional resources will be invested to accelerate accurate and timely claims decisions for veterans.

In closing, we understand the seriousness of the problems we face. We own them. We are taking decisive action to begin to resolve them. The President, Congress, veterans, VSOs, the American people, and VA staff all understand the need for change. We must, all of us, seize this opportunity. We can turn these challenges into the greatest opportunity for improvement, I believe in the history of the department.

Furthermore, I think that in as little as two years, the conversation can change, that VA can be the trusted provider for veterans' health care and for benefits. Our ability to do that depends on our willingness to seize the opportunity, challenge the status quo, and drive positive change.

I deeply respect the important role that Congress and the Members of this committee play in serving veterans. I am grateful for your long-term support and will work hard to earn your trust.

We cannot succeed without the collaboration and support of veteran service organizations. I conducted some 20 meetings and calls in the last two months with VSO leaders and other stakeholders to solicit their ideas for improving access and rebuilding trust. And I look forward to hearing the VSO testimony on the panel that follows.

And, last, I appreciate the hard work and dedication of VA employees, the vast majority of whom I continue to believe care deeply about our mission, want to do the right thing, and work hard every day to care for veterans. Because of their work today, Thursday,

today, hundreds of thousands of veterans will receive great care in facilities all the way from Maine to Manila.

And in the midst of this crisis, it is all too easy for us to forget that simple fact. Mr. Chairman, I am prepared to take your questions.

[THE PREPARED STATEMENT OF SLOAN D. GIBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Secretary, and it is an honor to have an opportunity to work with you, call you a friend.

We have got some questions that we are going to ask today and both sides will have some pretty probing questions. And I think we appreciate the actions that have been taken at the department to move the veterans off of wait lists.

And I think probably one of the significant questions that needs to be asked right now is how many veterans currently are on waiting lists over 30 days for appointments?

Mr. GIBSON. Do you want to take the wait list question and I will address the broader issue?

Mr. MATKOVSKY. Veterans on the EWL or electronic wait list number about 40,000 nationwide today, down from 57,000 May 15th.

Mr. GIBSON. The new enrollee appointment request list which was another focal point for this overall effort started at roughly 64,000. It is currently sitting on what is really going to be a permanent level of about 2,000 because there is flow in and out just about every single day.

When you look at the number of veterans that are waiting, that are scheduled, but waiting longer than 30 days for their appointments, it is about 640,000 total. We see the number of veterans waiting longer than 90 days as we release information each two weeks. We see that coming down steadily, but not precipitously, not fast enough.

The CHAIRMAN. If we can talk a little bit about the funding request that you alluded to in your—

Mr. GIBSON. Yes, sir.

The CHAIRMAN [continuing]. Opening statement. Is this a formal request being made by the President? Is it an emergency request, a supplemental request?

Mr. GIBSON. What I am trying to do here is to articulate the requirement as best as I can possibly articulate it. From my perspective, it is a formal request for funding.

The CHAIRMAN. From the Administration?

Mr. GIBSON. That is my understanding, yes, sir.

The CHAIRMAN. Is anybody aware of how the supplemental request was made by the White House in regards to the process crisis that exists on the border right now, \$3.4 billion?

Mr. GIBSON. I am not aware of the method by which it was conveyed.

The CHAIRMAN. It was a supplemental request from the White House. And so I am trying to figure out, because everybody keeps dancing around the word request, even yesterday, an under secretary did here on The Hill, and I am trying to find out what do

we—you know, it is a desire, but ordinarily it would come through the White House. And so walk me through. How did this come up right now? What was the impetus that began you looking at the need? We already got \$35 billion on the table and so now during negotiations on a conference committee report, you have injected \$17.6.

Mr. GIBSON. I think as we launched into, now over two months ago, we launched into an effort to accelerate care for those veterans that are waiting the longest, we undertook simultaneously a process of evaluating the adequate resources in the field in order to be able to meet that standard of consistent high-quality health care, timely, high-quality health care.

As we work through that process using the information systems that we have available to us, we developed an initial set of requirements and began working with the Office of Management and Budget.

As my testimony last week to the Senate became closer and closer, nearer and nearer, there was an increased effort there to try to get that process to closure so that during that testimony as well as this testimony that I would be able to present that statement of requirement.

The CHAIRMAN. So the memo that you gave to Senator Sanders on the 16th of July says per your request, attached for your information is a summary for additional resource needs through 2017.

So was it Senator Sanders' request, a combination, or yours?

Mr. GIBSON. Senator Sanders requested the information, the information, the requirement that is being communicated here, and, if you will, the request is our request.

The CHAIRMAN. You come from a banking background. If somebody came into your bank with three pieces of paper and asked for a million dollars, would you give them a million dollars?

Mr. GIBSON. The honest answer there is it probably would depend on who the borrower was. But I understand your point. The committee needs additional information.

The CHAIRMAN. And we have set a goal of trying to wrap up the conference committee by the end of next week before we leave so that we can get something to the President for his signature. And we got three pieces of paper to justify a request that Senator Sanders clearly wants put into the scope of the conference, making it very, very difficult for us to be able to do our job if all we get are sheets of paper that basically says they are working documents. At some point, they have to say this is the document.

With that, Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Once again, I want to thank you, Mr. Secretary, for being here.

You stated in your statement that VA doesn't have the resources that it needs. In your view, what led to this lack of resources, number one, and when was this under-resourcing identified? And my third question is, what did the department actually request in their budget?

The reason why I ask that question is when I first became a Member of this committee, when I was first elected, we had Secretary Principi sitting where you are sitting and we asked him as he was defending the President's budget and the question was can

you deliver the services for our veterans with Iraq and Afghanistan and the current. His response was, he requested an additional \$1.2 billion, did not receive it, but he will make due with this budget.

So I would be interested in knowing what your actual request was when you originally submitted your budget.

Mr. GIBSON. First of all, as I have come into the department five months and six days ago, I formed opinions about what I see and what I hear. My general sense is that what we have done historically is we have managed to a budget number as opposed to managing to requirements which is what you do in the private sector.

And I think as a result of that, what has happened is we have sort of muddled our way along and not been able to meet the standard of care that veterans deserve because we did not manage to requirements.

The exercise that we have gone through and, frankly, continue to go through as we work to ensure that we are ringing all the productivity that we can out of the existing resources is really about managing to requirements.

I would tell you that process, as I mentioned in response to the chairman's question, has really been underway for about the last two months. I have been in place as the acting now for seven weeks. And so we are working through that process.

In the private sector, this would be a routine part of the business. You would be managing to requirements. You would be continuously exercising productivity tools and over a period of years, you would be building the organizational capacity to ensure that you have got the responsive resources to be able to meet existing demand. That is simply not the way the department has historically been run. We have managed to a budget number instead.

I can't answer your question about what the specific budget request was in relation to what was actually finally approved, but we will take that one for the record and get you an answer.

Mr. MICHAUD. I appreciate that and I appreciate your comments because that was my same response to Secretary Principi at the time was I don't care how big of a budget increase you received. I want to know are you taking care of the veterans. The outcome is so critical.

And over the years through several secretaries I have sat here and listened to, I believe that they have always operated the department based upon the budget they had, not what they need to take care of our veterans. And hopefully that will change.

Mr. GIBSON. Well, if I may interrupt, sir. I committed to the President, I committed to employees at VA, and, most importantly, I have committed to veterans, I will not hold back. If I think resources are required, I am going to ask for them. And I have told the internal staff don't you ask for one penny more than you can justify.

You know, I am not looking here for some kind of a blank check, but I am not going to sit here—in my meetings with individual employees as they raise issues about the needs that they have and the resources that they lack, you know, I have come to understand what my job is.

My title may be acting secretary, but my job is to create the conditions for them to successfully meet the needs of the veterans that

they serve. And that is what I am obligated to do when I come here and sit in this seat.

Mr. MICHAUD. I appreciate that.

Do you think the business operating model that the VA currently operates is sustainable in the long term?

And getting to what Chairman Miller had mentioned, when you look at the fact that at the VISN level, they have exploded with management. And I think the VA definitely has to be reorganized and, you know, in a better format.

Do you think the current business model is sustainable in the long term?

Mr. GIBSON. My sense is that there are opportunities for us to structure differently. I don't like bureaucracy, but I understand in an organization as large as this one, you have got to have some of it. The challenge is making it work for the people that are serving veterans day in and day out. And I don't think we are doing that very well.

So I think there are opportunities. There has been concentration at the VISN level and at the VA central office level. Part of that I would tell you I think was positively done as part of taking and consolidating support activities either at the VISN level or at the VHA central office level where they can be performed more efficiently and effectively than they can scattered in 150 different locations. But that doesn't mean that we got it exactly right. There is still work to do there.

Mr. MICHAUD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Lamborn, you are recognized for five minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Thank you, Secretary Gibson, for being here today.

And I want to follow-up on something that was brought up earlier by Chairman Miller, a very important issue that I would like to get more information on, and it has to do with where you said in your statement we don't have the refined capacity to accurately quantify our staffing requirements.

And, yet, in your \$17.6 billion resource requirement, you are requesting \$8.2 billion for about 10,000 primary and specialty care physicians and other clinical staff.

Given that you said that the department is unable to quantify its staffing needs, how can a number like that even be arrived at?

Mr. GIBSON. I am going to let Philip Matkovsky, who is intimately involved in helping to develop the estimates, address the fundamental question.

I would tell you generally speaking what we have got, as I said earlier, we have not been working to solve to requirements. I think earlier today some of the staff participated and I think Congressman Wenstrup may have participated in a briefing that we delivered about the operation of our ophthalmology specialty.

And inside that model when you look at some of the productivity tools that we are now rolling out into the organization, you get a good microcosm of what ultimately is going to give us the kind of granularity. We are going to find as we exercise that model there are some locations that have enough staff.

There are some other locations that may need some additional support resources, either some additional support staff or additional space, and then there are going to be other locations where we look and we say we have enough providers here. And it is going through that kind of bottom-up, highly granular process that is going to give us the precise answer.

And we are working and doing that right now. But in the meantime, as we go out in the field, as I go out in the field and as we look at top-down requirements, it is clear to us that we do not have the resources we need.

Philip, the process that we have used.

Mr. MATKOVSKY. The one thing I would indicate is we tried to use a bottom-up approach which was looking at veterans who are waiting greater than 30 days for care and forecasting that into fiscal year 2015, 2016, and 2017.

We made certain assumptions about improving efficiency over the years and that for us gave us the definition of the count of appointments that we needed to accelerate and cost in the model.

Then we worked with the assumption that in year one, we are going to do mostly purchasing of care in the private sector because of staffing issues that would take time. And then we would blend it over time and sustain it using internal staff.

But the way that we came about that was estimating the number of veterans and their appointments that wouldn't be delivered in a timely manner, then costing that and turning that into the \$8.2 billion.

Mr. LAMBORN. Okay. Well, it sounds like it is a work in progress as you both are saying. So I question how specific you can actually be.

But a follow-up question is, are there a lot of slots that are sitting empty right now that you haven't been able to find someone to fill, either a doctor or other health care professional?

Mr. GIBSON. I would say yes, there are thousands of vacant positions. All across VHA, roughly 28,000 vacant positions. And in some instances, those aren't all being actively recruited to fill. I would tell you as part of accelerating care we have been pushing particularly on clinical staff and direct support staff to accelerate some of that hiring.

Mr. LAMBORN. Well, then my follow-up question there is if you have 28,000 minus X open slots and you add 10,000 or so more open slots, are you ever going to even be able to fill those slots under current requirements?

The current productivity requirements you have which I understand from testimony is different than in the private sector.

Mr. MATKOVSKY. I think organizations will always have some measure of organic vacancy rates. You will have turnover in your staff. But what it allows us to do is to raise the floor so that the floor of the fully encumbered positions grows with additional staff brought in.

So I think there will be staff that leave the organization. People leave. They retire. They move on to other jobs. There will be a vacancy rate. Our vacancy right now is about 10 percent and that sort of reflects the turnover rate. So as turnovers occur, you have a certain vacancy rate.

The other thing we are looking at, though, at the same time that we are doing this is looking at our position management practices. Rather than hiring to vacancy, hiring to the requirement which may require in certain cases that we have fully encumbered staff as opposed to where we are today.

But to your point, I think the additional staff allows us to raise the floor of the on-board FTE.

Mr. LAMBORN. Okay. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Was Ms. Brown here at the gavel?

Ms. Brown, you are recognized for five minutes.

Ms. BROWN. Thank you, Mr. Chairman.

And I want you to know I was here before the chairman.

I have been on this committee for 22 years. In fact, when I came, Jesse Brown was the secretary and his motto was putting veterans first. And I have been through all of the secretaries and, you know, some of them left a lot to be desired and some was—but the point of the matter is that I understand that VA has changed over the period of time.

And at one time, we were serving a certain kind of veteran. Now we have expanded to the veteran. I don't want to say they are sicker. Their conditions are different because of the war. They come back with different ailments.

How can you plan for that, because they want their services at the VA? I want to make sure that the VA is there for them. And it is a lot more complicated than what we are seeing because, like you said, they have 10 additional things as opposed to at one time. It was maybe a lot more simple than it is now.

Mr. MATKOVSKY. We have an actuarial model that we use to forecast. Part of that looks at the past practice and then forecasts into the future. That is part of it. The other part, I think, though, is to start introducing more bottom-up planning and having our field give us, if you will, the statement of requirements, so if this is the number of veterans that you think you can serve.

I also think that, and I neglected to mention this for Congressman Lamborn's question, if we improve performance, that is if we are better at providing high-quality and timely care, that is going to affect veterans coming to the VA. They will come to us more if they can get care more timely.

So having a bottom-up planning approach and working with our medical center leadership and our network leadership to give us a bottom-up operating plan of what their financial requirement is in the out years, I think will also help us be better prepared to adjust for where we are succeeding and when we succeed.

Ms. BROWN. And someone said that we have given the VA everything they requested. Now, I guess institutional memory should be important because I remember in 2007 and 2008, it was the first time that the veterans was able to get the budget that they requested, forward budgeting. You know, that was under President Barack Obama. I know I am the only one that remembers that.

But, you know, it is important to remember how you got where you are. As we move forward, you need to remember that many of us talk the talk, but we didn't walk the walk or roll the roll. So

I think that is important for us to remember how we got where we are.

And VA, yes, we are having problems, but we are not to the point that we need to destroy the system. And I feel very strongly about that and I don't want to be the only one saying that the VA shouldn't—I mean, I think we should work with community partners and community stakeholders.

And how do you feel about that? We have teaching hospitals that we should partner with. We could share equipment. But I still want VA to be in charge.

Mr. GIBSON. Yes, ma'am. You know, as I travel around and visit VA medical centers, one of the—

Ms. BROWN. You just returned from Gainesville.

Mr. GIBSON. Yes, ma'am. And at medical center after medical center, I am impressed with the academic affiliations that we have with local partners in the community and the benefits, all the many benefits, the extraordinary care that that has allowed to be made available for veterans, the expert staff, clinical staff that we are able to recruit in part because of those strong affiliations. It is one of our opportunities to continue to pursue.

Ms. BROWN. Thank you very much. And thank you very much for your service.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. I yield back the balance of my time, sir.

The CHAIRMAN. You got 42 seconds.

Dr. Roe, you are recognized.

Dr. ROE. Thanks very much, Mr. Chairman.

And thank you, Mr. Secretary, for being here today and thank you for your service in this tough time.

I agree with your opening statement. I have said this from the very beginning. One of the problems that VA has, that it did have was loss of trust. And I think Ms. Brown brought up the point a minute ago that a previous secretary, and I have said this from the very beginning, what the motto should be of the VA is we work for the veterans. I don't work for the VA, but I work for the veterans. So I think those things, that cultural change will help.

One of the things that I am just not sure about having more people is going to solve the problem because when I came on this committee five and a half years ago, a quarter of a million people worked for the VA, 250,000 people. And the number I saw in your testimony was 341,000. That is more people that work for the VA than any city in my district. It is huge.

And I am just not convinced getting bigger is going to solve the problem. I think getting better will solve the problem and getting more efficient will solve the problem, but I don't think—getting larger may make the problem worse. I honestly believe that.

And when you see an office go from 800 people at a VISN level to 11,000, that is mind boggling to me that that many more people could be needed when you don't have that many more employees. And I think you are looking internally. I truly believe that.

A question I have is, you mentioned accountability, has anyone been held accountable yet and terminated?

Mr. GIBSON. There were three actions that were announced dealing with Phoenix back about two months ago. There is an addi-

tional individual, senior executive manager that has been placed on a leave of absence. I would tell you——

Dr. ROE. But is there anybody that doesn't have a job that had a job?

Mr. GIBSON. There is nobody——

Dr. ROE. Nobody at all being fired? Has anybody——

Mr. GIBSON. Well, I understand what being fired means. And I am also learning the hard way how you do that in the Federal Government. And so, you know, it starts when you create this massive base of information that is documented.

The end of June, I got the first results from the IG finally released on one location, a thousand pages of transcripts of sworn testimony. And in the midst of all of that, there still wasn't all the information needed, so we had to dispatch additional investigators to go take additional testimony.

We reviewed all of that. We pulled email traffic and then we go through the process of I have to delegate authority for a proposing official and a deciding official. And they have to review all the information.

There are two things going on right now in the accountability space.

Dr. ROE. Mr. Secretary, let me interrupt you because my time is short. You have just made my point. When you were in the private sector, did you have to go through a thousand pages——

Mr. GIBSON. No.

Dr. ROE [continuing]. And do all this to fire somebody?

Mr. GIBSON. No. No.

Dr. ROE. The answer is, no, you didn't. And so creating more inefficiencies in there, I think more people making this bigger before we trim it down and make it better is not the right direction.

And I want to very briefly, I don't have a lot of time left, but we are going to try to have to make some decisions, big decisions in the next week or so that involve a lot of money, the taxpayers' money. And it is \$17 billion or that is the request.

And as the chairman pointed out, I have asked every time we have had a budget hearing, I have asked do you have enough money to carry out your mission. And the answer each time has been, yes, we have enough money to carry out our mission.

So how will I know this is enough money when I have been told before you had enough money because I voted for every single budget? That is one of the things I will never apologize for up here is to spend money on our veterans. I absolutely will never do that because I think they have served this country. We would not have this country the way it is that I enjoy and have grown up in if it were not for the veterans of this Nation.

So that is not an issue, but I don't want to take the money that hard-working people including veterans go out and pay taxes and not spend it wisely. So can you tell me how this \$17 billion, and that is \$17,000 million—where I am from, that is a lot of money.

Mr. GIBSON. A lot of money where I am from too.

Dr. ROE. How is it going to be spent and can I know that it will be spent wisely? And would it be better to take some of that money and not look at building this bigger bureaucracy but to veterans

who want to—if a veteran says I would like to go to see my doctor outside, just let that veteran do that. Would that not be cheaper?

The infrastructure is already out there. The hospitals are already out there. We had those folks in here a week and a half ago, I guess a week ago it was today, who expressed the desire to do that and they had the capacity to do that. Wouldn't it just be easier and more efficient to do just that?

Mr. GIBSON. You know, one of the points that was made earlier in one of the opening statements was the fact that veterans are pleased with the care they get. It is just once you get it. It is hard to get it.

Dr. ROE. I agree, but they are pleased with the care they get in the private sector, too, for the most part.

Mr. GIBSON. The other thing that has been interesting to me is we have been working down these lists and we call veterans that are waiting too long for care and we ask them do you want us to refer you out into the community. Sometimes the answer is yes, but more often than not, the answer is no, I want to wait for my appointment inside VA.

Dr. ROE. Mr. Chairman, just one thing I want to tell you. I had a sergeant in my office this week. I am not going to say who. But he called the VA to cancel his appointment. He was on hold for two hours, two hours. He just walked around his office doing his job.

And then later when he had an appointment, he—you all have done something, I will tell you that, because he said he got eight different phone calls from eight different people about his appointment. Now, is that efficient or is that inefficient?

Mr. GIBSON. It doesn't sound very efficient to me, sir.

Dr. ROE. I yield back.

The CHAIRMAN. Thank you very much.

Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Secretary, point blank, is there a shortage of doctors at the VA and, if so, what areas are the shortages in?

Mr. GIBSON. I would say the short direct answer is yes, there are shortages and there are shortages in primary care and specialty care and in mental health, all three.

Mr. TAKANO. Mental health is a big portion of the shortage. I have heard that there is problems referring people to specialists, so certain areas of specialty care is in deficit.

What are the VA's most successful physician recruitment tools and does the VA need stronger tools for recruitment?

Mr. MATKOVSKY. I think we have a number of very strong improvement tools. One of the areas where we have done a lot of work is in surgery. The surgery program has actually made significant use of informatics to actually look at practice, process, and then to identify deficiencies. That program runs nationally and is able to actually support both at the regional level, national level, and local level tracking and trend—

Mr. TAKANO. Recruitment tool.

Mr. MATKOVSKY. Recruitment.

Mr. TAKANO. Recruitment.

Mr. MATKOVSKY. I said improvement tools. Geez. I am very sorry, Congressman.

One of the areas that had come up before, would we look to have tuition reimbursement and other kinds of authorities like that provided. And I think looking at costs, those are valuable. And I think we need to look at extending those.

Mr. TAKANO. But recruitment is going to, that kind of recruitment, tuition reimbursement presupposes that there is a supply that is adequate to recruit from.

We know that doctors are more likely to stay in practice in the place where they completed graduate and medical school education. GMEs seem like one of the best recruitment tools that hospitals have.

Is the VA GME effectively?

Mr. MATKOVSKY. I think we are. I think where we find that we don't have a really good strong academic affiliate, sometimes we have challenges. And where we have developed a strong academic affiliate, we have a good pipeline of quality providers who want to work for the VA. They have done work in the VA. They were introduced. They understand our mission. They love our mission and they come to work for us.

Mr. TAKANO. Would you welcome funding to expand the VA's GME program?

I know that nationally the VA has normally been 10 to 12 percent of graduate and medical school education with Medicaid and Medicare taking the other 90 or so percent. We have been frozen at a number since 1996. I have to think that that is contributing to a shortage of doctors generally.

Mr. MATKOVSKY. I would have to look at that. I mean, I would say that conceptually we would support it, but I just need to look at the details.

Mr. TAKANO. Well, I mean, do you think this would help address the physician shortage at the VA if we were to be able to get and to get more timely care to our veterans if we were to increase the number of graduate and medical school education slots at the VA?

Mr. MATKOVSKY. I think so.

Mr. TAKANO. Is my time up, Mr. Chairman?

Ms. CHAIRMAN. No.

Mr. TAKANO. Okay. With the current fee-basis system, has the lack of interoperability between the electronic health records at the VA and non-VA providers been a barrier to providing high-quality continuity of care to our veterans?

Mr. MATKOVSKY. I think one of the things that separates us when we talk about private sector and other sort of fee-for-service systems, for instance, Medicare, is the requirement that we have. We have the responsibility to maintain continuity and coordination of care. It has, Congressman Takano.

I think in some of our contract options, we have the ability to exchange electronic data and that is written into the contract. So we actually get clinical documentation back.

Mr. TAKANO. Here is the thing. You know, I think many of us support the idea of non-VA access given our emergency situation, cooperation with county, both public and private. We support that, a lot of us on the democratic side.

But our concern about the solution that is the focal point of the funding is this potential lack of continuity. And is that part of your plan going forward?

Mr. MATKOVSKY. It is a part of it. We are looking at one of our major contracts that we have in place today to look at further making the data that we share back and forth computable. Today it is not computable. When we have individual authorizations for fee care, it will come in sometimes as paper and we scan it, image it, put it into the clinical record. In contracts, we get a PDF, but we need to make it data.

Mr. TAKANO. So we need more interoperability between the VA and non-VA care to really make outsource with the non-VA providers more feasible.

The IG, the interim IG or the acting IG said in the long run, the best efficiencies for the VA are going to be to own its own doctors and to keep care within its system. I mean, no system really, whether you are private or public, wants to outsource to out-of-network care. There is usually a huge charge to go out of network.

And I think the VA has the same sort of challenge, right? But in this emergency situation, we do want to make sure that when we do outsource that there is continuity of care.

Mr. GIBSON. As we look at purchase care in the community, we think in terms of extraordinary geography, extraordinary technology, and extraordinary demand. Clearly we are in a period right now of extraordinary demand that we are dealing with as we accelerate care to veterans waiting too long.

Extraordinary geography, there are always going to be communities where we can't justify building a CBOC. And so we are going to have to provide timely and appropriate access to care for those veterans.

And then there are going to be occasions where very highly specialized procedures, not going to make sense for us to do those in-house and want to refer them out.

Mr. TAKANO. I think many of us want to support more non-VA care, but we want to maybe set the parameters so it really is possible and really does work.

Mr. GIBSON. Correct.

Mr. TAKANO. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much.

Mr. Flores, you are recognized for five minutes.

Mr. FLORES. Thank you, Mr. Chairman.

Thank you, Secretary Gibson, for joining us today.

In your testimony, you said, quote, "We will work hard to earn your trust," unquote, we being the VA and your trust being the trust of Congress.

Your background and my background are fairly similar. We were both sea level officers in private organizations, you as a chief financial officer and me as chief financial officer and chief executive officer.

Now, in those positions, each of us had to report to boards who were responsible in a fiduciary manner for the oversight of the resources of those organizations. And so I am going to lay out the following sort of environment.

Let's say that you are the CFO of an organization that looks like this. It is a corrosive culture. It has performance measures that aren't trustworthy. It has senior executives who manipulated information in order to receive bonuses. Its past financial projects included requests for funding that caused funding levels to be higher than were not actually used, in this case by billions of dollars, and then those funds were reprogrammed to other purposes without letting the board know. And then you have a resource management system that according to your own testimony is not accurate.

So in light of that, what do you think the board's reaction would be if you go to it and say I need a whole bunch more money and I am only going to give you three pages to explain it?

So that is sort of the first part of the question. The second part of the question is, wouldn't it have been much more wise to come and say we need a small amount and we are going to come back to you in a few months and show you what a great job we did with this small amount and then say in light of that, we would like to make a larger request because we are on the right track? So that's my first question.

Mr. GIBSON. Well, I think the sense is that we needed to provide, as the conference committee was considering other appropriations, we needed to provide our best estimate of the requirements to meet the current demand.

Mr. FLORES. But you turned those requirements into a request and I don't think that was wise. I think it would have been a lot smarter to come back to us and say this is the down payment that we need and if we are successful at turning this around and putting veterans' health care first, then we're going to come back to you and ask for X, Y, and Z. But you asked for the whole enchilada at one time.

And that has caused a lot of us to struggle. And now we have got other folks that are trying to latch on to that and say that has got to be an integral part of the deal to reform the VA. I just don't think that is a good idea.

Let's go into a little bit more granular information. In the health care model that the VA uses, it is called the enrollee health care projection model or EHCPM, that takes into consideration a number of components, projected number of enrollees, projected workload, projected unit cost for providing the services.

In fiscal 2011 and 2012, the VA used the EHCPM to estimate the resources for about 83 percent of its health care budget estimates. In 2014, it expanded the use of EHCPM to develop cost estimates beyond that.

Over the years, the GAO has identified many problems with the EHCPM. In essence, it is not a very trustworthy product. And so that is an issue.

And now the Administration is requesting \$17.6 billion which I think was an unwise request to ask without proving that things are going to get better.

So here are my questions and I am going to run out of time, but you can answer these supplementally, hopefully before the end of today.

Number one is, was the EHCPM used to estimate the additional \$17.6 billion needed to clear out the current backlog at the VHA?

Number two, why did the EHCPM fail to predict the demand on the VHA system and is there a way the model can be adjusted to incorporate reasonable wait times? And, number three, and this is the most important one, should we continue to advance appropriate VA health care funding if clearly the method used to predict the funding needs so far in advance is not working?

As I said earlier in my testimony, the VA overestimated and then used the funds for other purposes again without talking to Congress or its board, if you will. And so the model just goes all over the place. Now you are saying that it needs \$17.6 billion.

So let's ask the first question. Did you use EHCPM for the \$17.6 billion budget estimate?

Mr. MATKOVSKY. Indirectly. We used costs, unit costs that were derived from the model, but looked at appointment wait time and used the data that we had for veterans waiting for care greater than 30 days. That is different than the model, though.

Mr. FLORES. Okay. So the only thing from the model is the unit costs; is that correct?

Mr. MATKOVSKY. Yes, sir.

Mr. FLORES. Everything else was starting—

Mr. MATKOVSKY. Looking at the data that we had at the time.

Mr. FLORES. Okay. Do you know why the EHCPM failed to predict these estimates in the past?

Mr. MATKOVSKY. I don't know that it did fail to predict it. I would have to go look at the details.

Mr. FLORES. The facts say it did fail.

Mr. MATKOVSKY. Okay.

Mr. FLORES. But, anyway, get back to us on that—

Mr. MATKOVSKY. I will.

Mr. FLORES [continuing]. As well as my third question. Thank you. I yield back.

The CHAIRMAN. Thank you very much.

Ms. Titus, you are recognized for five minutes. Ms. Titus, you are recognized.

Ms. TITUS. Excuse me, Mr. Chairman.

Well, I think we all agree that the purpose of these hearings and of your proposed reforms is to increase service to our veterans and to their families. These are services that they have deserved.

And I thank you, Mr. Secretary, for being here and all that you propose to make that happen.

We have heard of all the many problems and if these problems exist generally for veterans, I think that the problems are perhaps even worse for our LGBT and women veterans. And that is where I would like to address my concerns.

I would ask you, Mr. Secretary, do you believe that veterans and their spouses should have equal access to federal benefits through the VA regardless of their current state of residency?

Mr. GIBSON. Yes, ma'am, I do.

Ms. TITUS. Well, I thank you for that answer. And I ask you this because last month, the VA announced that your agency has exhausted all avenues in the wake of the decision by the Supreme Court in Windsor versus the U.S. that struck down DAMA for giving benefits to our LGBT veterans.

And unless Congress acts, those veterans and their families who live in states that don't recognize their marriages will be denied access to earned benefits; is that correct?

Mr. GIBSON. That is correct, yes, ma'am.

Ms. TITUS. Well, and that is most unfortunate. But because of that, I recognize that need. And after the Supreme Court decision, I introduced H.R. 2529. That is a very simple bill that would correct that language problem in the statute.

We had a hearing on that last March. Nobody came forward to oppose it. We had VSOs speaking in favor of it. Nobody is working against it.

And I would ask you would you support our efforts here in Congress to make that change so all our veterans who have all worn the uniform, who have all served equally, who served the United States, not a particular state, could have access to those benefits?

Mr. GIBSON. Ma'am, I am not familiar with the legislation specifically, but my own policy decisions at the department have been to provide equal benefits to all veterans to the maximum extent permitted by the law.

Ms. TITUS. And I thank you for that, and our veterans do, too, I am sure.

As for women, I would like to ask you about that. Some of the recent reports have highlighted some very disturbing statistics about the low quality of care that our women veterans face. And they are less likely to seek out care. They are often called our silent veterans.

But when they do, we found that the VA served 390,000 vets last year, yet nearly one in four of the VA hospitals does not have a permanent gynecologist on staff. And one out of every two female veterans received medication that was determined could have caused birth defects even though they are at an age where they might want to have children.

These are unacceptable statistics and they really address the question of quality of care. I sent a letter along with 50 of my colleagues here in the House asking that this be addressed. I know you have been busy. I haven't heard back from you.

But I wonder if you could speak to that this morning.

Mr. GIBSON. Well, I owe you an answer, first of all, apologies, and we will get you one. We are, quite frankly, playing catch up. The growth rate in women veterans that are coming to VA for care radically outstrips the overall growth rate in the number of veterans that are coming to VA for care.

We have not historically been well positioned to provide that care. We are doing things. We are training for existing providers, hiring additional providers as well as I know what a big deal it is every time we are able to cut the ribbon on a new women's clinic in a medical center because I always get invited and I attend as many of those as I can.

So it is a really big deal, but we are playing catch up and we have got work to do.

Ms. TITUS. Well, I appreciate that, and I thank you for your answers because sometimes we look at this in the big picture and we forget that there are certain veterans who are perhaps being overlooked. And I want our improvement of services to go for all our

veterans because they have all served and sacrificed as have their families.

So thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much, Ms. Titus.

Looks like, Dr. Benishek, you are recognized for five minutes.

Dr. BENISHEK. Thank you, Mr. Chairman.

And thank you, Mr. Secretary.

Frankly, your story of coming in, you know, in the interim like this and trying to pick up the pieces of a system that has obviously been under, you know, a lot of stress is admirable and I appreciate what you are doing.

I have a couple of quick questions—

Mr. GIBSON. Yes, sir.

Dr. BENISHEK [continuing]. That I hope you will be able to help me with. First of all, I just want to address a personal issue. You know, the CBOC in Traverse City, Michigan has been scheduled to be increased in size for years. And, actually, the money is apparently in your department and all it needs is a signature from you to get that to happen.

So I would like to get your signature on that to make that. My district has been waiting for this for years. And the money has been appropriated and it is in the budget, but, you know, we have been trying to get this to happen for a long time. So I hope you can fix that.

Mr. GIBSON. We will dig into that one, sir.

Dr. BENISHEK. Well, I have been trying to get this to happen for a long time.

Mr. GIBSON. I've got to tell you when I am out in the field, I run into all kinds of instances where—

Dr. BENISHEK. Well, you know, I appreciate the fact that you are out there.

Mr. GIBSON [continuing]. Before I leave the room.

Dr. BENISHEK. I appreciate that you are out there yourself seeing what is happening on the ground because, you know, my problem with management is that when somebody is sitting back behind their desk and listening to their subordinates tell them how things are, that is when trouble happens.

Mr. GIBSON. Yes.

Dr. BENISHEK. And I think that is what has happened in the past, frankly, here.

Now, the question that we brought up and some of the Members brought it up earlier is what does the secretary need to do his job? You mentioned how difficult it is to remove people, so what would your recommendations be to—what powers should the secretary have that he doesn't have now to make sure that change happens?

Mr. GIBSON. That is not an easy question to answer. I have said repeatedly I will use whatever authority I have got and use it to the maximum extent that I can to hold people accountable.

There are different proposals out there about granting additional authority to the secretary and if those are provided, then we will use them. We recognize that to the extent that those are targeted solely at the Department of Veterans Affairs, that has an impact over time on our ability, I believe—

Dr. BENISHEK. No. You are explaining a lot, but you are not giving me an answer. What do you need to make this happen better?

Mr. GIBSON. Well, you know, somebody asked a question earlier about is that how it worked in the private sector. I would tell you, you know, let's work like we do in the private sector. But that ignores a century of authority and——

Dr. BENISHEK. Well, what is a century of mismanagement? Let's make a step forward. What would the number one thing that you would recommend to make it easier for the secretary to do his job and promote accountability and action?

Mr. GIBSON. Well, I think the flexibility to expedite personnel actions.

Dr. BENISHEK. All right. Thank you.

Mr. GIBSON. That would be a big deal.

Dr. BENISHEK. Let me ask another question and that is, we are trying to get the patients off of waiting lists and into the private sector, so, you know, my experience with the VA is it is very difficult to make that happen because there is like so much paperwork that the veterans have to go through.

What have you done in this emergency situation to make it easier for that veteran actually to get out into the private sector and make it happen and the guys get paid and it all is happening quickly? Now, what have you actually done to make this happen?

Mr. MATKOVSKY. That is a good question. Congressman Benishek, one of the things that we have done is we have created these new tools. I know we have talked about them before, non-VA care coordination. It helps us to automate the documentation of the referral so that it occurs a little bit faster.

But what it also allows us to do is it for the first time, we get to look at that referral through all of its stages and we get to manage to it. So we get to look at when was the referral created, when was it authorized.

Did we sit on it too long before we authorized it? After it was authorized, when was the appointment scheduled, how much time passed, and then, finally, when was the care delivered and the documentation returned?

That is helping us. It is not perfect yet. We still have work to do. I think——

Dr. BENISHEK. Well, what exactly are you doing to get these people off the waiting lists and into the doctor's office in the private sector? Tell me how that process works.

Mr. MATKOVSKY. So specifically it is phone calls to veterans asking them if they would like to be seen in the private sector if they would. And we can coordinate with PC3. We are using our PC3 partners——

Dr. BENISHEK. PC3 is not in place for the most part?

Mr. MATKOVSKY. Not fully, but where it is, PC3 will coordinate that appointment for us and where it is not, we are working with veterans. If they know a provider they want to work with, they will work with their own provider. If they don't, we will work to set up that appointment with providers we have relationships with.

And there is a scripted process. We did script it this time. I think it is a little bit better. We still have a lot of work to do to get that done right. Actually, we have even talked with some VSOs to help

us look at that process from a veteran's perspective. Is it easy to understand? Is it easy to follow through? I think we have work to do there.

Dr. BENISHEK. I am glad you admit to that. Thank you.

The CHAIRMAN. Dr. Ruiz, you are recognized. Excuse me. Mrs. Kirkpatrick, you are recognized for five minutes.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Secretary, thank you for being here today.

On Monday, I was out on the Navajo Nation in my district and talking with lots of folks. And we have a lot of veterans and many of them live in areas with no cell phone coverage or broadband coverage. And I know one of your goals is to expand tele-medicine and that is a great opportunity for my district.

But my first question is is, in your budget, do you have money for expanding broadband infrastructure in those areas where we have veterans who have no access?

Mr. MATKOVSKY. I think it is one of the things we will have to look at. In the supplemental request, we did have additional support for IT to include hardware and bandwidth for expanded care. But I think we need to look at that specifically. I don't want to give you a false answer.

Mrs. KIRKPATRICK. And I would love to be part of that conversation as we continue on because it is going to be so critical to getting them the care they need.

My other question is for the secretary. I mean, you know, the inspector general's reports have been very valuable to this committee in trying to unravel the problems at the VA and come up with real solutions, and just would like to know what you have done, what you have put in place since the interim report from the inspector general in May.

Mr. GIBSON. There were a series of findings and recommendations that were included in the IG's May report, most of them having to do with first working the list of 1,700 veterans that they had turned up in their process which we have reached out to every single one of those. I think roughly a thousand appointments have been or appointments for a thousand veterans had been scheduled as a result of that particular process.

There were recommendations in the report about producing the NEAR report, the new enrollee appointment request report, producing that at the medical center level and distributing that out so that it can be worked. That has happened. And as I mentioned earlier, the NEAR list has gone from 64,000 to—it was 2,100 the last time I looked which is going to be about the bottom of that.

There were items that I am not remembering. Seems like there were one or two others.

Mr. MATKOVSKY. Yeah. Each one of them became a specific action plan. We have worked on them. We have, I think, closed them. We have implemented their recommendations in the interim. Whatever the IG—sorry, sir.

Mr. GIBSON. I got it. There was also a recommendation regarding reviewing wait lists nationwide which obviously we do. We are producing them and publishing them every two weeks. And those are really the four or five recommendations and we have vigorously pursued every single one of them.

Mrs. KIRKPATRICK. Well, I thank you for that effort.

And I just want you to know I visited recently with a doctor at Flagstaff Medical Center and they had just entered into a contract with the VA to treat local veterans. And they were very happy and pleased to do that.

So with that, I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Dr. Wenstrup, you are recognized.

Dr. WENSTRUP. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here today and for your many years of service to our country in many, many ways.

You know, let me just start by let's take the assumption that the goal of the VA is to see all those that are eligible for care as soon as possible and provide quality care. And that I think should be the assumption there.

But what I find is that the motivational factors that are really needed to accomplish that and to achieve that on a regular basis and to comply with human nature don't really exist. In other words, the incentives aren't necessarily there that would exist in the private sector, et cetera.

And I am curious how you would propose in this mass bureaucracy that we are dealing with from administrators to physicians and nurses to those that are support staff, how do we create an environment where truly seeing the veteran patient is an asset rather than a liability to the system?

Mr. GIBSON. Interesting way to frame the issue. As I mentioned in my opening statement, I continue to believe when I go out to the field—I was in Phoenix several weeks ago and visited with a roomful of employees and, you know, that is clearly our most troubled location faced with what I have characterized as leadership failure, mismanagement, chronic under-investment and, yet, person after person raised their hand and talked about the things they were doing, the things they had to overcome in order to be able to take care of their veterans.

I still find everywhere I go the vast majority of people care deeply about the veterans that we are serving. And I would tell you if we didn't have that, I wouldn't have anything to reach in and grab a hold of. As I try to take this organization in the direction that we need to go in, being able to reach in there and grab a hold of the fact that they care, they want to do the right thing is a critical, critical element of what we are doing.

I would tell you other structural things. And, again, I alluded to it in my opening statement. I have got situations where quality of care at a medical center is declining and medical center directors are getting top-box scores on their evaluations.

And that was what prompted my direction to say we are going to overhaul the standard performance contract for medical center directors and VISN directors because we are not going to have a contract where their result isn't aligned with the patient outcomes that we are delivering.

And I think it is going to take some of those kinds of structural changes as well to ensure that we got people focused on veterans.

The last thing I would say to this point, you know, we are so focused on wait times. And as we think about how we gauge timeli-

ness of access in the future, I think the centerpiece of that is going to be a much more robust focus on patient satisfaction. I think that helps us recenter back on the veteran that we are serving and not looking at wait times and the 700 other metrics that we have got people trying to—

Dr. WENSTRUP. And those types of responses should be the driving force to whether someone gets a bonus or how they are compensated.

Mr. GIBSON. Yes.

Dr. WENSTRUP. And, you know, inspector general implied to us that as money over the last decade has increased, it led to more layers of administrative aspects rather than actual care. And that really is a concern.

As you know, I had a meeting this morning with several Members on measuring productivity and efficiency which we have done a couple times with some of the doctors here. And I think they are going in the right direction, but I still think that there is some things missing. When you evaluate just based on RVUs, what you are able to look at is how much we are paying the doctor per RVU. But there is a lot more that goes into that for us to be efficient.

And this comes into when we are asking for \$17 billion, right? And so, for example, if you have an old physical plant, you know, you have got to take a look at how much you are spending for productivity and RVUs in a plant that is costing you out of this world. You may be better closing that entire facility and putting everything in the community in that particular spot.

But we are not measuring that. Those are the types of things we have to measure as well because when you talk about outsourcing and saying it costs, maybe it doesn't cost more if your physical plant is costing you so much more. Those are business decisions and that has got to be the approach. We can't assume that where we are is the best place to be always.

So I am going to continue to work with that group and with you. And hopefully we can see these types of changes. And I appreciate it.

And with that, I am out of time and I yield back. Thank you.

The CHAIRMAN. Thank you very much.

Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I appreciate it very much.

And thank you, Mr. Secretary.

Mr. Secretary, the way I understand your proposal of the \$17.6 billion is predominantly for additional space, additional personnel, professionals, and some money for IT. And I certainly agree that in terms of facilities and personnel, there is a need.

My CBOC in Oxnard, California has, as you stated in your testimony, is one that has had double digit increases each year over the last couple of years and not much has been done over those last couple of years, I will add.

I think what I have learned through all of the hearings that we have had that the care for veterans once they get in the system is pretty good. It is accessing the system is where we have seen is truly broken.

And when I see the IT proposal there, it concerns me. It is a red flag for me because you did mention off-the-shelf products that you are looking at, off-the-shelf technology that you are looking at.

But I really want to know. We have got to fix the access part of this and I don't want to invest more money into a broken system. I want to invest money into new technologies and innovation and getting the VA into the 21st century much like the private sector is and the tools that they have to access a health care system.

So if you could just comment on that, please.

Mr. GIBSON. First of all, I would say the majority of the IT resources, as I understand the proposal here, are associated with the activation of the facilities, so it is the IT infrastructure that we need as we activate facilities and bring on additional clinical staff.

There are a number of things underway to really take us into the 21st century here. Part of it is the purchase of the commercial off-the-shelf scheduling system which is not included here. It is already provided within the core funding.

But there are other things. We were talking about interoperability for purchase care and there are technology investments that are included here associated with that.

Philip, anything else to add?

Mr. MATKOVSKY. I would just add a couple of items relative to the IT. I mean, part of it is we have a capital request in there and we are requesting a certain amount. I think it is about 12 to 13 million square feet for leased space, but we have to outfit that leased space with IT actually to make it useful to connect PCs, cables, networks, wireless, telecoms, et cetera. Sorry.

Mrs. KIRKPATRICK. Yeah, I can't see. I'm sorry.

Mr. MATKOVSKY. So that is a part of it. So that is built into it. It is not all just raw development work. It is what you need actually to make use of the space you get and then to actually connect the staff you are hiring. You need IT to make that happen. So that is part of the request.

Mrs. KIRKPATRICK. So, Mr. Secretary, then in terms of off-the-shelf solutions that you are speaking of, what is the time frame in that? What are we looking at?

Mr. GIBSON. Sure. There are actually three or four different initiatives, kind of parallel initiatives on the scheduling front. We have already let a contract to deal with some of the most challenging aspects of the current system and we are expecting those to begin to be fielded within the next six to 12 months.

The time line for the purchase of the commercial off-the-shelf system is still a bit up in the air based upon the contracting approach that we are going to have to pursue there, but I think 2016 is probably the best case scenario for the introduction of that particular system.

Does that sound right, Philip?

And so that is one of the reasons we are going ahead to make the investments in the fixes to the existing system so that we don't wait two years to have that improved functionality.

Mrs. KIRKPATRICK. Thank you.

And very quickly, in your opening comments as well, you talked about the VBA and the improvements there. We also learned in our hearings that we have had a 2,000 percent increase in the appeals

with regards to benefits. So when you add that together, to me it gives me pause in terms of believing that we have made the improvement.

And if you could just briefly comment on that.

Mr. GIBSON. Sure. Glad to. There has been this laser sharp focus on the disability claims backlog. I perceived that walking in the door the morning of my third day at VA. I was over at the White House talking about the backlog and VBMS. And so, you know, this laser sharp focus on the disability claims backlog, we have not been as focused as we needed to be on non-rating claims and on appeals and on our fiduciary claims.

And that is what we are really talking about doing here, particularly with appeals where the majority, 90 percent of the number of appeals that are in process sit in VBA. We have allocated additional resources, thank you very much to Congress's support, to the Board of Veterans Appeals which is helping us and we are using some technology there to make them more efficient.

But we have work to do in the VBA side to be able to provide—

Mrs. KIRKPATRICK. Thank you. I yield back.

Mr. GIBSON []. Timely decisions.

The CHAIRMAN. Thank you.

Dr. Huelskamp, you are recognized for five minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman. Appreciate your continued leadership on so many issues and appreciate the opportunity to question the acting secretary.

And I want to bring attention first to a very famous publication, Life Magazine, May 22nd, 1970. I presume you are somewhat familiar with this publication and also the photo that gained much attention across the country of, again, May 1970 in which the VA was found to have abused the trust and neglected our veterans.

And, Mr. Gibson, I think we sit here today and that is the same topic, how are we going to restore the trust to our American veterans and to the American people. And what I have heard from you today so far has been that if we will spend, give you another \$17.6 billion, somehow that will restore that trust. And I don't think that does that for my constituents, certainly not for my veterans.

And I have some very specific questions I would like to ask of you. First of all, have all secret waiting lists been eliminated and identified?

Mr. GIBSON. To the best of my knowledge, yes, they have.

Dr. HUELSKAMP. You have identified, at least Mr. Matkovsky identified those on the electronic waiting list, but it is my understanding there are 18 different schemes identified internally. So you are absolutely certain that every one of those waiting lists have been identified?

Mr. GIBSON. I don't know where the number 18 comes from.

Dr. HUELSKAMP. That comes from the OIG report and, actually, from a memo in 2010 that came from your department. I just say if we are going to restore trust—

Mr. GIBSON. Well, the IG is in over 80 locations right now and I am not privy to what they are finding. So that is why I say to the best of my knowledge, they have been uncovered. But until the IG completes their reviews in all those locations and comes back and issues their reports, I can't tell you that definitively.

Dr. HUELSKAMP. Well, how do we restore that trust if we don't know the extent of the problem?

Mr. GIBSON. Well, I think you start where you are.

Dr. HUELSKAMP. You start by spending money?

Mr. GIBSON. No. You start where you are. You start by articulating expectations about how we are going to operate. You start by getting veterans off of wait lists and into clinics. You start by fixing the chronic scheduling problems that exist within the organization.

Dr. HUELSKAMP. Well, how do we know we are achieving progress? What we have heard and I am sure you are aware of numerous employees from the VA have come before this committee—

Mr. GIBSON. Yes, they have.

Dr. HUELSKAMP [continuing]. And identified falsified data, fake data presented to this committee. And you come in here today and present data and say, hey, we are making progress.

How do we restore the trust that we can actually believe the data you are presenting to the committee?

Mr. GIBSON. I would tell you when I directed all the medical center directors and VISN directors to go out and spend time in each of their clinics and engage with their schedulers, you know, people have asked me, well, gee, that doesn't sound like much of a check and balance because they are on the inside.

The real motivation behind that direction was for them to be out there on the ground and to take ownership for the quality of health care that is being delivered including the timeliness of the health care that is being—

Dr. HUELSKAMP. Well, the whistleblowers that I hear from, Mr. Secretary—I am short on time—they are saying that has not changed.

Mr. GIBSON. We are coming behind that. We are coming behind that with an independent audit, comprehensive audit of scheduling practices all across the organization because we need to restore that trust.

Dr. HUELSKAMP. Has anyone lost their job for retaliating against—

Mr. GIBSON. No, there has not. There are two whistleblower retaliation referrals that have just come from the Office of Special Counsel. And Tuesday morning, I will have investigators on the ground pursuing those specific—

Dr. HUELSKAMP. How many ongoing investigations are currently underway for investigating these retaliation complaints?

Mr. GIBSON. Oh, it is 70 or something.

Dr. HUELSKAMP. Seventy.

Mr. GIBSON. The number is—

Dr. HUELSKAMP. And so we are going to hear about two and the other 68 are still ongoing?

Mr. GIBSON. These are ongoing at the Office of Special Counsel. I am waiting for the Office of Special Counsel to provide me the results of their investigation. I can't—

Dr. HUELSKAMP. What are you doing about it?

Mr. GIBSON. What I can do—

Dr. HUELSKAMP. What we heard from whistleblowers is—

Mr. GIBSON. What I can do——

Dr. HUELSKAMP. Let me describe what we heard from whistleblowers. Maybe you didn't hear that. But they said we get an email once a year that says we have a right to whistleblow.

Mr. GIBSON. What I can do is——

Dr. HUELSKAMP. And then we are faced with retaliation. I am hearing this still going on today.

Mr. GIBSON. I have no doubt that it is. I can articulate over and over again the expectation that we are not going to tolerate that behavior. But until I have got a set of facts that I can act on, I can't take the action. I can't take the personnel action. And so nobody is more anxious than I am to have that opportunity.

That is why, in fact, this morning, I checked again have we gotten anything from the Office of Special Counsel. The answer was yes, we just got two. Tuesday morning, we will have investigators on the ground at that level.

Dr. HUELSKAMP. I requested in the last meeting, following the last meeting information of contacts between a whistleblower here that had contacted the chief of staff to the President. I don't believe we received that information.

Your department can look into that. You have access to the information. You just need to call Mr. Nabors. That hasn't been looked into. That hasn't been responded to. These are very serious allegations, Mr. Secretary.

And I presume we are going to have a new secretary in a couple weeks. But to come in and say we are going to restore the trust, but we haven't addressed the whistleblower problem because that is somebody else's job, that if you give us \$17 billion——

Mr. GIBSON. No, it is not somebody else's job. It is my job.

Dr. HUELSKAMP. No. It is the OIG's job.

Mr. GIBSON. I just can't take action until I have got the results of the investigation.

Dr. HUELSKAMP. From the OIG. So we are waiting on——

Mr. GIBSON. Either from the OIG or from the Office of Special Counsel, one or the other.

Dr. HUELSKAMP. Have you issued any new statements to the VA system about whistleblowers?

Mr. GIBSON. Yes.

Dr. HUELSKAMP. Okay. Could you provide that to the committee? I yield back, Mr. Chairman.

Mr. GIBSON. Yes, sir.

The CHAIRMAN. Thank you very much.

Dr. Ruiz, you are recognized for five minutes.

Dr. RUIZ. Thank you so much, Mr. Chairman.

Thank you, Secretary, for your hard work.

Before I begin, I want to recognize a friend of all of ours, Nancy Brown Park. She is the national president of The American Legion Women's Auxiliary who is here in our room today. She is visiting us from my district, California's 36. And as you know, it is in southern California, so it is a long trek.

Thank you for being here and thank you for all your hard work.

You know, recently my office has really done an incredibly detailed, thorough investigation of the different issues that face our veterans not only when I started office last summer when we held

community forums, stakeholder analysis, research but also key stakeholder interviews.

We underwent that again in light of this crisis. We have a veterans' advisory board that is just top notch. We conducted surveys. We did more interviews and had multiple meetings with the Loma Linda VA and the VA Administration.

And we recently conducted this informal survey of veterans in my district to assess their satisfaction with access to the VA health care.

But, you know, our approach means the world of difference to veterans and we approach this with a spirit of problem solving. We approach this with the spirit of partnerships for solutions. We approach this with the spirit of honoring our veterans with our relentless determination to serve and put them above anything else.

And we found, and I am going to give you some information, though, and we understand there is some selection bias here, so I take these numbers with a grain of salt, but, nevertheless, they tell a story, we found that the vast majority of my district veterans who responded said that they waited more than 60 days. Of course, these are individuals who are upset and who are willing to conduct this survey.

When asked what issues were preventing them from obtaining timely care, about a third said that they cited a shortage of staff which is echoing the concerns raised by Secretary Gibson and the VSOs represented here today.

Even more troubling, when asked what could be improved to better provide timely care, the vast majority again said, quote, "people who care." And we have heard that on multiple occasions.

So we also heard that there is this culture where the VA system believes that perhaps it is about them. And we need to change that culture to make it a more high-performance, veteran-centered culture. The VA exists to honor, respect, and give dignity and care for our veterans who have put their lives at risk. The veterans do not exist to serve the VA health care system. That is very important for that sentiment to penetrate every level of the VA health care system.

Now, my question to you is, what is the plan for a system-wide cultural change that will create a culture of high-performance, veteran-centered system?

Mr. GIBSON. I think as you look at organizational change, cultural change in an organization, the critical ingredient in all of my experience is leadership. Part of that has to do with articulating expectations and then holding people accountable for behavior that is aligned with those expectations.

You know, we are working hard to do the first part. We are working hard to get ready to do the second part. And we are anxious to do the second part as well because, quite frankly, I think that is where we begin to get real traction.

I would also tell you on the leadership part I agree with you completely. I think there is a fundamental shift in culture that has to happen. One of the things that I talk about an awful lot internally is ownership really at all levels, and we are talking about leaders not at the top of the organization, but leaders at all levels, taking

ownership for issues that are getting in the way of delivering care to veterans.

In some instances, it could be a leader that is taking ownership for a greeter's less than cordial welcome of a veteran. It could be more fundamental in terms of a leader taking ownership for the steps that need to be taken to get X-ray machines repaired in an operating room as I ran into in Phoenix.

But it is really about taking ownership and understanding that, you know, my job, as I said earlier, my job is to create the conditions for them to successfully take care of veterans.

Dr. RUIZ. I believe that that is very important. That leads to a culture of accountability which we absolutely need.

Mr. GIBSON. Yes.

Dr. RUIZ. However, we need a veteran-centered culture. So what are you being held accountable for? What are the institutionalized tools that you are going to use to make sure that our eyes aren't necessarily on the spreadsheet but are always on the veterans themselves?

And that can be done with veterans' advisory boards. That can be done with veteran surveys. That can be done with tying promotions—

Mr. GIBSON. Yes.

Dr. RUIZ [continuing]. To veteran satisfaction. That can be done in a lot of different ways that focuses on all of our eyes, all of our accountability, everything we do, everything that we strive for and exists even in our high performance always answers the question through the lens of the veterans.

Mr. GIBSON. Agree.

Dr. RUIZ. Thank you. I yield back my time.

The CHAIRMAN. Thank you very much, Dr. Ruiz.

Colonel Cook, you are recognized, sir, for five minutes.

Mr. COOK. Thank you, Mr. Secretary. Appreciate you being here.

We are talking about trust and confidence. And I will be very honest with you. I lost a lot of trust and confidence in the VA. You know, when I was in a platoon, felt very, very confident with the troops that I had, the company commander, trust and confidence in the battalion all the way up there. And I am trying to, you know, not let the events of the past, you know, influence my judgment.

About three months ago, I called one of the VAs. I am not going to call as Congressman Cook. I am not going to call as Colonel Cook. I just said, hey, this is Paul Cook. You know, I am on file in there. I just want to get an appointment. I couldn't even get past the switchboard. Okay?

Called the VA, the regional office and told them about that, but there is part of me that wanted to go to war, if you will, but there is part of me that my office, they do a great job handling the veterans and I didn't want to endanger other cases that are on file.

So, anyway, I said to myself, okay, Cook, what are you going to do. You are a dumb marine. So I said, all right, here is what is going to happen. I am going to walk into a VA and I am going to try and get an appointment. I am going to bring my ID card. I probably will not show them first. I just want to give them my driver's license. They are going to look at it. Right away they are

going to see I am older than dirt. But it will have my Social Security number on there.

And what I want to know from you guys, if you can, what five questions should I have answered right then and there so I can go forward with the process because if I think those questions are working, I am going to spread that through every veteran that, hey, you going to VA, make sure you have blah, blah, blah, blah, blah, and you ask these questions because I am going to say if they didn't answer those questions, then we have a problem and we have to address it. And I will come back to you and here we go again.

Sorry. It is a long question, I guess.

Mr. MATKOVSKY. I think to get care in any VA, you should ask only one question, am I enrolled. If you are enrolled, you should be getting care. The second questions after that would be what kind of care would you want. If you are not enrolled, the second question after that would be I would like to enroll, how do I do that.

Mr. COOK. I am enrolled. Let's go with that.

Mr. MATKOVSKY. That should be just the one question, I am enrolled and I would like to get an appointment.

Mr. COOK. Then the next one? Just ask—

Mr. MATKOVSKY. I would like to see my primary care provider. I would like to see this provider. That is it. You shouldn't be asking any other questions.

Mr. COOK. Okay. So two questions—

Mr. MATKOVSKY. Yes, sir.

Mr. COOK [continuing]. Or three questions. Okay. Got a couple of questions of the IG. The IG, you might not be able to answer. How many of the IG visits are unannounced?

Mr. GIBSON. I am sorry. How many IG visits—

Mr. COOK. Are unannounced.

Mr. GIBSON. I would say the large majority.

Mr. COOK. Okay. So they don't know in advance that they are—okay.

Mr. GIBSON. Oftentimes they are responding to a hotline call or something like that. I don't even know where the IG is—

Mr. COOK. Yeah. But, you know, I mentioned this before about the principle, and I was an IG, so this thing about managing by walking around where sometimes you walk into a battalion or what have you, you know, you don't like to do that when you have evidence that there is something going on with the unit.

I walked in one time. I found a live mortar in a place with the bore riding safety pin off. Unbelievable. And, yet, when you come in like that, particularly if you are worried about an organization based upon the statistics that have gone out there.

So I don't know. I am kind of excited about you being here. You answered your question. I still don't understand granularity and it is the third time I have heard it in two committees in the last two days. It took me a long while to understand *pseudomonas aeruginosa*, *escherichia coli*, and tricuspid valvelectomies, and now you throw that at me. I am just a dumb marine, but I am glad we are going to start over again and we are focused on it.

And Dr. Ruiz is right. It is about the culture of the military and we can never forget that. Thank you.

I yield back.

The CHAIRMAN. Thank you very much.

Mr. O'Rourke, you are recognized for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Secretary, let me begin by thanking you not only for being here but for the amazing job that you have done in under two months as the acting secretary. You have been incredibly responsive. You have been transparent. You focused on issues of accountability and I believe you have defined a vision for excellence even in the first two minutes of your opening statement.

And my hope is that as we have a new secretary for the VA that you will still be part of this organization at the very highest level continuing that very aggressive, ambitious push towards excellence and accountability and changing this culture that all of us have been working on and talking about for so many months and in some cases years now.

Let me quickly switch to El Paso, and I realize it is parochial, but I hope that it has some implications for others who have similar situations in their districts and for the system as a whole.

You visited 13 facilities, I believe. El Paso was one of them. The amazing Verna Jones from The American Legion also set up a command center there within the last month. That shows us that you are taking this issue seriously, but it also shows us that we have a problem in El Paso.

The access rankings that we saw from the VHA reported in June showed that out of 151 facilities, we were dead last, absolute worst for established veterans' access to mental health care appointments. We were fourth worst for new veterans' access to mental health and second worst for specialty care.

You in some of your comments that you made while you were in El Paso talked about problems with the capacity of the facility that we have, the quality of the facility that we have. I would love for you right now to say, Beto, I am going to help you with a full-service veterans' hospital. I am not going to ask you to make a commitment that you can't follow through on and don't have the power to implement.

But I will ask you this. Will you work with me to ensure that we can increase capacity, that we can improve the level and quality and access to care in El Paso and similarly under-served, poor-performing facilities in this country?

Mr. GIBSON. I absolutely will. El Paso is one of those locations that has grown almost 20 percent over the last three years. It is located, as we both know, in a medically under-served market.

And so we have got challenges there as it relates to space, as it relates to the scope of services that we are providing organically in that particular location, and challenges in some instances, which you have personally helped us with, in terms of trying to attract clinicians to come to work there.

Mr. O'ROURKE. Let me, if you don't mind, Mr. Secretary, I told you Friday that I was going to call a psychologist who we were trying to recruit to El Paso. When I was sworn in in January of 2013, we had 19 and a half vacancies in mental health care in El Paso. As of last month, we had 19 and a half vacancies in mental health care in El Paso.

I have been making recruitment calls. I spoke to a wonderful psychologist yesterday, a leader in PTSD care. I learned that because we are a clinic, she will be a GS-13 most likely. That will be the pay scale. If she were coming to a hospital, she would be a GS-14.

I cannot blame her or anyone who would make a decision based on what they will be able to earn in a position given the fact that they are coming into a historically under-served area. It is another piece of the case that I am making that we need a full-service VHA hospital in El Paso.

Quickly switching gears, the chairman and ranking member convened an amazing panel week before last of survivors of servicemembers who have taken their lives as they transition into civilian life. And we talked about PTSD and the need to do a better job of taking care of these servicemembers when they come back.

And the parents of Daniel Somers, Dr. and Mrs. Somers, also provided a potential solution or at least a suggestion for us to explore and that was, and kind of picking up on something that Dr. Roe said about how we coordinate with community care and private care, could the VHA become a center of excellence for war-related injuries for survivors of PTSD, of TBI, of musculoskeletal injuries, of exposure to toxins like Agent Orange and those that our servicemembers were exposed to in the Gulf War, and have community care for all other services.

I am not endorsing the idea, but I would love to get your thoughts and perhaps Mr. Matkovsky's thoughts with the chairman's permission since I am close to running out of time.

Mr. GIBSON. Well, I think the first part of the question should we become a center of excellence around a lot of those practice areas, I would tell you we either are or should be. And so those are instances where we need to have deep knowledge and expertise but also exceptional capacity to be able to meet the needs of servicemembers there.

How that fits into a revised model of VA care delivery, you know, I don't know that I am ready to give you a view on that, but clearly in those particular areas, and as I learned from our friends at PVA, oftentimes the things that VA has over the decades developed deep specialties in are absolutely vital to our veterans. And these are great examples of today's areas.

Mr. O'ROURKE. As I yield back, I would just ask that we continue to work together to at least explore this concept. Perhaps the VA cannot be everything to all veterans and maybe we should focus on centers of excellence.

With that, I yield back to the chair.

The CHAIRMAN. Thank you, Mr. O'Rourke.

Mrs. Walorski, you are recognized for five minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman.

And, Secretary Gibson, it is an honor to meet you. I appreciate you being here.

I just want to take a second and just let you know why I am stymied by this request for \$17 billion because I just want to take you back how this started on the committee.

I am from the State of Indiana. We have 6.2 million Hoosiers that live in the State of Indiana. We have a half a million veterans

out of 6.2 million people. Our State is passionate and they are freedom fighters. We love the military. We embrace the VA in the State of Indiana. We have the fourth largest national guard in the Nation, a little tiny State in the Midwest behind California and Texas. We love and we are patriots in our State.

So I am passionate about this issue because I believe that when our little State, a half a million people answer the call and they heard a promise from this government, and I have sat here for 18 months with a lot of my fellow freshmen on this committee, and I still have for you today the original questions I asked when these hearings began because we have never got an answer from the VA.

And all we wanted to know, all I wanted to know was, what is the status of my State? What is happening with the clinics in my State?

I have gone to several hospitals in my State. I have a hospital that is not even a fully functioning hospital. They don't even have an ICU. So if you are a veteran that comes in, you are going to be looked at in the ER and shipped across the street to a private facility and, yet, taxpayers are paying for both.

I have got a large institution in Indiana I went through two weeks ago that had probably two-thirds beds empty and they have never been called by the VA on the supposed nationwide check. They showed up on the list of 122 original audits that the VA had additional questions from and the CEO personally told me he has never heard a word. Nobody has ever checked with him. There have been no checks.

Nobody has been fired. They are still harassing whistleblowers. There have been no checks. We don't know the status of our states. We can't get the answers to the questions that we started with.

And I guess the question I want to ask you, but I am almost mortified to hear your answer is, when will we know the status of our states? Mr. Matkovsky has been here before. I am sure I have asked those questions from day one, but when are we going to hear the status of our states? And please don't tell me it is up to counsel general, it is up to the IG and everybody is cryptic and mysterious and anonymous.

Mr. MATKOVSKY. Monday and Wednesday of next week, Congresswoman Walorski, myself and maybe one or two of my peers will be conducting eight-hour briefings here to the committees both in the Senate, the House, and all the State delegations. We will also be sending that data out to the field as well so that what we provide to you, we provide to the facilities and the networks themselves.

Mrs. WALORSKI. Perfect.

Mr. MATKOVSKY. So Monday and Wednesday.

Mrs. WALORSKI. Yea, because that has been a huge concern.

My second question goes back to Representative Brownley's, which is we have sat in here on many, many hearings on IT. And, in fact, I will never forget the gentleman in charge of IT was sitting where that blank microphone is right now. And your IT, according to the hearings that we have had, has been a disaster. There have been many breaches. Our veterans have had their information co-opted and breached.

And the gentleman that was in charge of IT sat there and I said to him, do you have enough money to do what you need to do to protect our VA and to protect our veterans and to upgrade the systems that you need. Yes, ma'am.

We find out during a subsequent hearing that, and the \$17 billion request, that we have allocated long before I got here, this committee has consistently, faithfully allocated all the money the VA IT department has asked for, and then we find out a revelation in one of these hearings, that they are using 1985 scheduling software. And I think that is one of the most shocking revelations I heard.

So in one of the hearings just a few months ago, I said where are the billions of dollars, where did they go in this giant VA? They obviously weren't addressing IT.

And when you come to us and ask for \$17 billion and nobody can answer the question of why we are using antiquated equipment, when every request has been funded, the IT at the VA is a disaster.

What is the answer to the question of how can we possibly trust you now even for another billion just for IT when all that money has been unaccounted for and the revelation under oath was we are using 1985 software?

I think that is shocking and I think the American taxpayers deserve an answer as to where did their money go and how can they trust you with another \$17 billion or just \$1 billion in IT upgrade, either of you.

Mr. GIBSON. I was listening for a question there.

Mrs. WALORSKI. My question is, how can the American people trust you for more money, even a billion?

Mr. GIBSON. Be glad to come give you a lay down of the work that IT does on an annual basis, the projects that are undertaken, the systems that are both maintained and developed, and the functionality that is delivered.

Mrs. WALORSKI. So I guess, Mr. Chairman, if I could indulge just one final question, so I guess the information we heard that day from your IT, the guy in charge of IT was incorrect and it could not have possibly been correct information then for us to find out under a hearing where people are taking an oath that we are using 1985 outdated scheduling software when he simply sat there to me and said we need no more money, we are compliant, we are fine, thank you very much.

So the information he gave us then wasn't true, correct?

Mr. GIBSON. I think he gave you an honest answer. I think what you heard was the result of an organization that is managing to a budget as opposed to an organization that is managing to requirements.

I would tell you one of the things we need is a scheduling system. We have got it built into our budget for 2015 and 2016 and we are——

Mrs. WALORSKI. In all due respect——

Mr. GIBSON [continuing]. And we are going to——

Mrs. WALORSKI [continuing]. According to your professional, it was built into the budgets for years and we were funding it. And

we were trusting that it was used for the allocation that was requested.

Mr. GIBSON. There was a highly reported failed development effort that occurred back years ago where VA invested a substantial amount of money in a scheduling system and it wasn't able to deliver.

And I would tell you in the years since that time starting in 2010 when VA developed the project management accountability system, and I would refer to you and I will make sure that we get you a copy of the recent GAO report where GAO looked at seven different major departments and the progress that their IT functions have done, particularly in agile development which is the way we go about delivering software these days, VA was the only one of the seven departments that passed the grade with the GAO.

Mrs. WALORSKI. I appreciate it.

Mr. GIBSON. So lots—

Mrs. WALORSKI. And the other question I would love answered—

Mr. GIBSON [continuing]. Lots of change and improvement.

Mrs. WALORSKI [continuing]. Is if that guy who is in charge of your IT got a bonus, I am curious, for the information he has provided for the lack of adequate resources that you have. I want to know if the guy got a bonus. I would just appreciate it for the record.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. For Mrs. Walorski's knowledge and the rest of the Members, we actually were going to have an oversight hearing this week in regards to IT. We were not able to do it because the person who is responsible for IT is out of the country on a long-planned family vacation and so we cancelled in hopes that he would be able to attend on another date in the future.

Mr. Walz, you are recognized.

Mr. WALZ. Thank you, Mr. Chairman.

Mr. Secretary, thank you. I, for one, am thankful and grateful that this nation still producing citizens like yourself. I have had the privilege of working with you in other capacities on the USO and your commitment is unquestioned.

And I think when you started out, Mr. Secretary, when you talked about—I agree with you on this. This is one of our greatest opportunities to make lasting improvement. What we do possibly within the next weeks and months will have decades long implications. That is why it is important that we get it right, not just get it done; they are hand in hand.

I have been advocating that what has been missing is a national veterans strategy very similar to the Quadrennial Defense Review that sets that priorities, that gets that transition. Because I am interested—in a minute I am going to ask you about your commander's intent and the transition, if you will, as it goes to the next commander as we all know and how that will work.

But what I am hearing and I think what you are hearing the concern on this is, this nation is committed to getting this right. This nation is committed to providing the resources. But we also have a commitment, and they are not mutually exclusive, to ask that every dollar be spent in a wise manner. In trying to strike

that out—I am going back to best practices. Because I want to clarify when we talk about the private sector, let's be clear, eight out of ten businesses fail in the private sector. Don't pick the eight where you are getting your information. So this oversimplification, or if the Government is going to do it right and get into these ideological differences, that clouds it and I think it takes us away from the mission is there is best practices. There is things that are out there.

So I would ask you this, and this is what I would like to get your take on, Mr. Secretary: I have the privilege of representing the number one hospital in the nation, the Mayo Clinic, and I have watched and I have looked at and I understand how Mayo has done this and one of the things that Mayo has always, of course, been focused on is the patient first, just like we are talking about the veteran first, but systems analysis, from the very beginning over a hundred years ago has been at the mantra of what they are doing. And these things, as far as Baldrige criteria and performance excellence drives what they do. And interestingly enough, it starts on the flowchart with leadership and it ends with results.

And so my question is in Mayo, they have a quality academy—the levels correspond to Six Sigma and all of those things—they are asking, basically, and been there because—many people don't know this, but Mayo was basically founded on battlefield medicine—so they are deeply engrained into battlefield medicine, the VA, and they have partnerships with you. They are asking now what they can do. I guess my question is when Under Secretary Hickey said here, she talked about ISO 9001 certification, so if they can come back and answer where this is from. What are you suggesting or what can be done in VHA to ensure a Baldrige-type, Mayo-Six Sigma-type of performance so that then we know if we give you the money, how it is going to be implemented?

Mr. GIBSON. Interestingly enough, when we did a review of scheduling practices and access practices, we invited folks from Mayo to come brief us. When we looked at water safety practices and the VA, we invited engineers from the Mayo Clinic to come. So I would completely agree with you that they are a model organization.

I think one of the things we need to look at—I agree with your characterization that we should look at it as a system and look at our entire health care system as a system, not just focusing on a metric here, a metric there, but looking at concepts like throughput, looking at concepts like being veteran-centric and how do we measure, how do we manage, how do we assess that? I think over the next couple of months we are going to go take a look at some of our productivity work that we have done. We have briefed Dr. Wenstrup on it. Maybe bring some folks from the outside, and help us look at doing purposeful system changes. Not spot initiatives here and there, by looking at what the practice would look like if we changed it, maximized throughput, assess it with real clinicians, to Dr. Benishek's point, on the ground. Real physicians, does this work? Can we deploy it? Test it and measure it? Use the principals of measurement?

And then I think for the long-term sustainability, VHA and VA, but especially VHA, used to have these academies that were really

great and we sort of let that erode and we have to bring them back and we have to build leaders by focusing the training on them, building them over time, and investing in them to succeed.

Mr. WALZ. And I think that is what we want here. This corresponds to the quality of care. I think all stems from there, and I think this is an opportunity to build that hybrid, not this either/or, the private sector does it best, you do it here.

The core mission of the VA needs to remain intact. We need to strengthen it. There are certainly positive lessons out there in the private sector, Mayo and others, and we heard last week from a panel that offered up great suggestions. I thought there was a great one coming from Indiana. Mrs. Walorski was talking about Indiana University says he looks out the window and he sees five hospitals. He knows on any given day, they are only using 79 percent of their capacity. Let's tap that other 21.

So, Mr. Secretary.

Secretary GIBSON. Well, I was just going to say I was in St. Louis on Tuesday and had the opportunity to visit our training academy on the cemetery side of the business, and cited that as an internal best practice——

Mr. WALZ. Absolutely.

Secretary GIBSON. [continuing]. That we need to import into the VHA because we don't have the kind of talent development and succession planning inside VHA that you would find in a private sector.

Mr. WALZ. And I think it is important that you bring that back up again. The older members here will remember this, the crisis out at our cemeteries, out at Arlington and others, and the focus that was put on that and the turnaround that has been there and the verifiable turnaround and the quality that has been made. We can do this, but if we miss this opportunity or don't cease to rise to the occasion, then shame on all of us.

So, I yield back.

The CHAIRMAN. Thank you very much.

Mr. Runyan, you are recognized for five minutes.

Mr. RUNYAN. Thank you, Mr. Chairman.

And I am going to probably throw out a couple rhetorical questions and maybe some analogies to kind of set the table, and one you probably won't answer, but I just want to throw it out there and see if you can respond to why someone would even ask it: Is VA too big to fail? I mean that is something that we have dealt with in other sectors in the last decade. I think it is a legitimate question.

And when we talk about trust and processes, how are we going to get there? As Representative Flores said earlier, and you followed up answering Mr. Huelskamp's question about process, and your quote was, "On the personal factor, you need a set of facts to act on." That can be done in a budgetary process.

I will use the analogy. I will go back to your high school/college days. You know, your girlfriend broke up with you. You made up the next day, but you didn't ask her to marry her that day. A legitimate process of gaining trust over time. And to go to that, and I love the fact that you brought up manage to requirements. There is what, seven, eight members on this committee that serve on

Armed Services? And Mr. Walz brought up Quadrennial Defense Review. I think most of us that sit on that committee believes the DoD does the same thing; they tweak the requirements to meet the budget. They don't lay the whole thing out to Congress and allow us to say, at some point we are going to have to prioritize what we are going to do because there is only so much to go around, but we have to know what is out there. And when we are dealing with a crisis like this—and I asked the question to Under Secretary Hickey last week—I said, when we are attacking something and me and maybe the chairman—and we are attacking something like the claims backlog, that is a category of claims. Now, when you do your analysis to say we need this much money to solve this problem, are we going all the way back into everything from—and I know it changes on a daily basis—could you do it by a quarterly basis, a biannual basis to say to eliminate all of the claims in whether it is death benefits, whether it is burials, whether it is education, pension, all that kind of stuff, is that even possible to move the overlay of what we are making definitions of putting claims in piles, to say, do you have an idea of even what that number is, VA, why?

Because you are alluded to it on several patient aspects, but in an overall claims—because we continue to say well, we are only going to ask for this much because I put this overlay on it, what is the overall big picture? What is that requirement to eliminate this once and for all?

I don't think these questions really get asked and/or answered on a regular basis.

Secretary GIBSON. And you are talking about on the claims' side, on the benefits' side? I am not clear.

Mr. RUNYAN. Just to boil the whole thing down. Let's just say claims. Every single one of them that is sitting on a desk in an RO somewhere, what is that number and what is that fiscal number that goes to eliminate that? I mean because you are—a lot of times I know you talk a lot about modeling and all of that. Well, your models, you are using filters and layers to actually actuate those numbers that come out of those models. What is the big picture? Is the crisis bigger than we—I think we are realizing it is bigger than we thought it was a year ago, but can we, at some point, push all of this back and say we really got to step back and take a look at this and realize this is a bigger problem and we really need to dive into this deep.

Secretary GIBSON. You know, I think as it relates to both the claims side of the business, the benefits side of the business, if you will, and the health care side of the business, part of what you are seeing, and VBA has done this for some period of time, this regular, weekly publication of detailed information, not just about the disability claims, but also now detailed information about all the nonrating claims buckets, so that people have that complete picture.

The same thing on wait times. You know, up until six weeks ago, we weren't pushing detailed wait time information out on every single location—care quality and patient safety information out on every single location so that we are creating that kind of openness and transparency so that people can understand the magnitude of

the problem. So that as I sit here and say it is 641,000 veterans that have appointments that are more than 30 days from when they wanted to see.

Mr. RUNYAN. And I know my time is running out, and I just want to tell you that I have experienced this in my four years in Congress, as you build trust and we say we are going to do it one step at a time, I don't think that there is anybody on this committee that would have a problem coming in here and you tackling this \$10 million at a time. I don't think they would. As we do that and make sure we get it right and have that set of facts that we can act on, as you said.

So with that, I will yield back, Chairman.

The CHAIRMAN. Thank you, Mr. Runyan.

Ms. KUSTER, you are recognized for five minutes.

Ms. KUSTER. Thank you, Mr. Chair, and thank you so much, Secretary Gibson for being with us today and taking on this extraordinary task. We appreciate it. I want to echo the comments of my colleagues. I think that you will find that this is one of the very rare bipartisan committees on Capitol Hill right now when we strive to work together.

I want to focus in on the issue you mentioned, Ms. Bradley and the work on ethics and accountability, because what my concern is, is while I wholeheartedly believe that we need to do every possible thing to ensure that our veterans get the care that they deserve, I have a hard time addressing the funding request before we get into how the VA is going to fix this underlying systemic issue of integrity. In particular, the testimony that we have heard here about this scandal, of people receiving bonuses upon manipulated data, frankly, a lack of truthfulness—truthiness, if you call it, honesty, and integrity, that not only the veterans deserve, but, frankly, the American taxpayer deserves.

And so if you could address—before we get into the additional funding—how do you intend to restore that level of integrity throughout this system and what will be the actions taken for deceit and failure to abide by basic, basic issues of integrity?

Secretary GIBSON. Yes, ma'am.

When the President told me that he was going to have me to be the acting secretary, I said, "Don't expect me to behave like 'acting' is in front of the job title," and I have tried not to do that consistently. We have moved out on every front that we can conceivably move out on.

So it has been a process of working, not sequentially on tackling different issues, but working across a much broader front at the same time. So working to get veterans off of wait lists; working to fix scheduling issues; and simultaneously working to build the processes so we can hold people accountable for willful misconduct and management negligence when it arises.

As we went through this process I perceived the need for additional expertise in that area which is why I went and recruited Leigh Bradley and with Secretary Hagel's strong support, to come over to the Department, to return to the Department of Veterans Affairs. We have built underneath her a cross-functional team of senior leaders from across the organization. Part of the process—part of the challenge that we are going through the right now, part

of it is just what it takes in the Federal Government to pursue personnel actions and to have them done in a way that you at least hope it is going to stand up to an appeal.

The other challenge that we are working through right now is really the re-calibration of the Department's yardstick, if you will.

Ms. KUSTER. Uh-huh.

Secretary GIBSON. That behavior that looks like this, which in the past might not have had any accountability action associated with it at all, may, in the future be appropriate—deemed appropriate for removal from federal service or for very extended period of suspension.

So what we have done and as we have now, I mentioned earlier, got the first of these cases in from the IG, are now exercising that process; following due process, but also managing through this reset that has to happen, this re-calibration that has to happen to ensure that appropriate accountability actions are taken for the wrongdoing that has been identified.

Ms. KUSTER. And if there is anything that we can do in our capacity in congress and I know that, you know, including passing a bill to give you the authority to literally fire employees, because I think that is the only thing that is going to bring this integrity back.

And I just want to say, for the record, I had a tremendous honor this week. My constituent, Sergeant Ryan Pitts, received the Presidential Medal of Honor, and I was there for the ceremony with he and his wife, Amy, and son, Luke, at the White House and as he was inducted into the Hall of Fame at the Pentagon. I was very interested in his comments this morning on national television when asked about his own care at the VA, that the care he has received in New Hampshire has been a very high quality. But I want to say for the record that every veteran deserves that care.

And my time is coming up, but I do want to say is that I hope you will pursue best practices, because I think we have some exemplary care in New Hampshire and I'd like to see that throughout the country.

Secretary GIBSON. Yes, ma'am.

Ms. KUSTER. So thank you, and on that, I yield back.

The CHAIRMAN. Thank you very much, Ms. Kuster.

Mr. Secretary, I apologize. Some Members are going to have to depart to go to a conference committee meeting over in the visitors' center which is at twelve noon. We tried every way we could to find a time that was agreeable for everybody, but I am going to turn the chair over to Mr. Bilirakis at this time and recognize him for his statements. But thank you, sir, for your service, your candor, and I look forward to continuing to work with you.

Secretary GIBSON. Yes, sir.

Mr. BILIRAKIS. [Presiding] Thank you, Mr. Chairman. I appreciate that and I will recognize myself for five minutes.

Mr. Secretary, again, thank you for your service to our country. Mr. Secretary, are you aware of this incident that occurred I believe on Monday in an Orange County, Florida, facility, a CBOC, where a marine, a veteran was actually waiting three hours for care, did not receive that care, and then he was subsequently locked into a facility during closing time, so it was inadvertent, ob-

viously. I mean what are we going to do about this? This is accountability. Are you investigating this? Will the people responsible, the administrators, be held responsible?

Secretary GIBSON. All I know about it is what I read in the clippings this morning. It will be an object of intensive review to determine what happened and ensure that nothing like that happens again at that CBOC.

Mr. BILIRAKIS. Okay. Can you report back to me, Mr. Secretary, with regard to that?

Secretary GIBSON. Yes, sir. Will do.

Mr. BILIRAKIS. I mean it is outrageous, as far as I am concerned.

Next question: You have directed that an independent external audit of VA's scheduling practices be performed. What do you expect the external audit to reveal that VA's own audit has not—has a contract been awarded, and how long do you anticipate this to go on, and then I have a couple other questions to follow.

Secretary GIBSON. The contract has not been awarded yet which is why I am not in a position to be able to reveal the entity that we are working with. I believe once it is announced, the reaction will be that they must be pretty serious about making sure this gets done right.

Quite frankly, I hope it doesn't tell us anything that we don't already know. I hope it confirms that what we now have in place are scheduling practices that are aligned with our policies. But I think to some of the earlier questions that were asked about the need for some verification, you know, how do you believe—we are publishing wait-time data every two weeks—is it valid data? And one of the issues for us there is to look at the scheduling practices and have a rigorous independent review. Determine that they are sound practices aligned with our policy and, therefore, we have credible data for external consumption, as well as for our own internal actions.

Mr. BILIRAKIS. Okay. What is the expected costs of the audit?

Secretary GIBSON. I don't have a number for you. I will take that for the record.

Mr. BILIRAKIS. Okay. Very good. Thank you.

Again, with regard to the bonuses, have any bonuses been rescinded so far due to, you know, willful misconduct or negligence management? Can you answer that question?

Secretary GIBSON. I will give you the best answer as I know it. There were some bonuses that were rescinded recently that were associated with administrative error. The law allows us to do that.

Where there is a—something is learned after the performance period and after the performance contract has been officially—the performance review has been officially approved, we don't legally have the ability to go back and change that performance evaluation, and therefore, claw back that particular bone us. We do have the ability to go and reduce salary and take other actions which would be the typical actions upon some subsequent, learning of some subsequent information that affected performance during a performance period.

Mr. BILIRAKIS. Okay. Last question: I understand that you implemented a hiring freeze for the VHA central office and the VISN offices with the exception of so-called critical positions, to be ap-

proved by you in a case-by-case manner. What would you consider a critical position for a VHA central office and the VISN offices?

Secretary GIBSON. Well, I would say, for example, we currently have, if my memory serves me right, four vacant VISN director positions. And if we were in a—if we were where we had the right person identified to step into one of those key leadership roles, then I would be prepared to grant an exception for that personnel action.

Mr. BILIRAKIS. Have you granted an exception so far?

Secretary GIBSON. I have not for that purpose. There is one employee that I granted an exception for where he has already been made an offer and accepted an offer, and had already begun to relocate, and for that instance, I did grant an exception.

This is really focused on the roughly 3,000 people that comprise the VISN headquarters leadership, as well as the VHA central office leadership. There are other staff that are associated with those particular areas, such as call centers. We have thousands of people who work in our call centers in VHA and those would not be positions because they are providing—that would be subject to the hiring freeze—because they are providing direct service to veterans.

Mr. BILIRAKIS. How long will the hiring freeze be in effect?

Secretary GIBSON. Don't know.

Mr. BILIRAKIS. Okay. You can't anticipate how long, huh?

Secretary GIBSON. You know, the real purpose of that hiring freeze, very directly here, was to basically send a shot across the bow of the bureaucracy to say we have got to get ourselves refocused here on delivering the support that the frontline needs, the people that are taking care of veterans day in and day out. So that is really the purpose behind that particular freeze.

Mr. BILIRAKIS. Okay. Thank you very much. I appreciate that.

And I have Ms. McLeod, you are recognized for five minutes, ma'am.

Ms. NEGRETE-McLEOD. Thank you, Mr. Chairman, and thank you Mr. Acting Secretary for being here. However being near the end, all of the questions have been asked, so rather than being redundant, I yield my time.

Mr. BILIRAKIS. You are finished? Okay. Thank you very much. I apologize. Thank you.

I will recognize Mr. Fitzpatrick for five minutes.

Mr. FITZPATRICK. I also thank the chairman and I would thank the acting secretary for your time here today. I know that we all honor and appreciate your service. It hasn't been said here today about your time at the USO, which was a real turnaround, a great success, a great American story—

Secretary GIBSON. Yes, sir.

Mr. FITZPATRICK [continuing]. And I want to thank you for that. We saw that in Philadelphia with the USO organization there and, of course, we all hope that you can bring that enthusiasm and that success and bring it back to the organization at the VA—desperately needs it and needs your leadership there. And I echo the comments of some of my previous colleagues who said that we hope that you stick around the VA and continue—

Secretary GIBSON. I plan to.

Mr. FITZPATRICK. The VA is really a stool with really three legs and they are—we have the health administration here. We have the benefits administration here. Of course, the third is the cemetery administration.

As Mr. Walz said, in the past, you know, has not been without its issues, but I have to say coming from Bucks County, Pennsylvania, we have a new national cemetery, the Washington Crossing National Cemetery, beautifully being developed, serving very well the constituents of southeastern Pennsylvania, the greater region, and so the, you know, the veteran community, the families of military and the bigger communities is left with a very positive view of the Veterans Administration because of the cemetery administration there and the community; not so much with the benefits administration.

Mr. Secretary, I am sure that you are familiar with the hearing that we had here last week when we went well into the early hours of the morning. There was a whistleblower from Philadelphia, an outstanding employee, very dedicated employee who parenthetically, is a whistleblower for her work providing direct outstanding service to veterans and indirect service by going to her middle managers, pointing out flaws in the system. She's pointed out backlog and delays. She's pointed out double and duplicate payments that she thinks should be recalled and having been recalled. She pointed out shredding of documents, and for that she's been sort of vilified and set aside and made a victim herself, when really the administration and the management there at the Philadelphia VARO should be embracing her.

And I know that you were in Philadelphia a couple of weeks ago. My staff really appreciated your time and commitment in going through, but based on what you saw in Philadelphia and based on what you heard and what you now know, I would ask: What is the plan? What are the action steps to turn around the Philadelphia office, which would apply to many of the other ROs across the country?

Secretary GIBSON. That is a great question, Congressman. I think we are back to the earlier point of leadership. We have one of our most capable and experienced senior leaders that is in the process of relocating to take over that troubled location and I would expect in the wake of her arrival, to see steady improvement.

I have, as I go out to visit medical centers, I make a point to visit regional offices in the communities, and there are a number of those that I visited fairly recently, that not that long ago were not necessarily distinguishing themselves for a variety of reasons in terms of the timeliness or the accuracy of the work that they were doing or some other challenges and problems. And yet find that has we get new leadership in there on the ground, the right kind of leadership, that we see a very strong recovery and improvement and that is what I am looking for in Philadelphia and am expecting. It is a vital location for us.

Mr. FITZPATRICK. It is a change in leadership, but there needs to be a complete change in culture and there has been a lot of discussion of the number \$17.8 billion. I mean how many billion dollars does it take to fix a broken culture within the VA?

Secretary GIBSON. You know, I would say, as I was alluding to earlier, this is not a one-stage effort. This is not something, either, that we feel like veterans expect us to tackle some of these problems in sequence, because if we did, we would be three years before we got veterans out of a wait list the way they need to be gotten off of wait lists. So there are things that we are doing to get veterans off of wait lists; to fix scheduling practices; to address cultural issues; to enforce accountability; and along with that, part of that is identifying and quantifying the resources that we believe that we need over the next several years to be able to meet the time we can deliver care.

Mr. FITZPATRICK. And in my remaining little time here, I just want to get into this issue of the goal to eliminate the backlog. I don't see it in your written testimony, but I think you testified here today that you have an intent to see that backlog eliminated by—I think you said——

Secretary GIBSON. 2015.

Mr. FITZPATRICK. 2015.

Secretary GIBSON. Absolutely.

Mr. FITZPATRICK. And, you know, that is an audacious goal. It is one that I hope—I find it hard to believe, based on what I heard about Philadelphia recently, and based upon our own investigations where you have middle managers essentially cooking the books to the point where they with produce reports and send them up the chain of command to say, based upon these metrics, we have met the goal, but it is a hollow victory, which is no victory at all. Because we may look like we have met the goal and we may celebrate meeting the goal, but there still would be hundreds of thousands of veterans waiting to be served. So how do you address that?

We heard General Shinseki a couple of years ago say that we will eliminate veteran homelessness by 2015. How are we doing on that goal?

Secretary GIBSON. We make steady progress. That is one particular goal that doesn't necessarily lend itself to the most frequent and accurate measurement, but there is progress, steady progress being made in reducing the number of veterans who are living on the streets. And I would tell you, and I will say it again right now, I believe that we will eliminate the disability claims backlog in 2015. I think we are on track to do that; notwithstanding the challenges that we have got in a number of our regional offices. We have work to do.

Mr. FITZPATRICK. Thank you, Mr. Secretary.

Secretary GIBSON. Yes, sir.

Mr. BILIRAKIS. Thank you, Mr. Fitzpatrick. You yield back.

Well, if there are no further questions, you are now all excused and I will invite the second panel, the final panel for witnesses, all the witnesses to the table, please.

On our second panel we have Ms. Verna Jones, Veterans Affairs Director, for The American Legion. Welcome.

Mr. Ryan Gallucci, deputy director of the National Veterans Service for Veterans of Foreign Wars of the United States. Welcome, sir.

Mr. Carl Blake, Acting Associate Executive Director For Government Relations, Paralyzed Veterans of America. Welcome, sir.

Mr. Joe Violante who is the National Legislative Director for Disabled American Veterans. Welcome, sir.

Mr. Rick Weidman, Executive Director of Government Affairs for the Vietnam Veterans of America. Welcome, sir.

And Mr. Alex Nicholson who is the Legislative Director for the Iraq and Afghanistan Veterans of America. Welcome, sir.

Thank you all for joinings here this morning. Thank you so much for your patience. Your complete written statements will be made part of the hearing record.

Ms. Jones, if you are ready, you are now recognized for five minutes.

STATEMENTS OF VERA JONES, VETERANS AFFAIRS DIRECTOR, THE AMERICAN LEGION; RYAN M. GALLUCCI, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; CARL BLAKE, ACTING ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA; JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RICK WEIDMAN, EXECUTIVE DIRECTOR OF GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA; ALEX NICHOLSON, LEGISLATIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA.

STATEMENT OF VERA JONES

Ms. JONES. I wonder how many people in this room would bet their last \$40 in a long-shot chance to make some sense of the VA.

Mr. Vice Chairman, Ranking Member Michaud, on behalf of the National Commander Dan Dellinger, and the 2.4 million members of The American Legion, thank you for your diligence and oversight during this crisis.

The American Legion has spent the least six weeks in five cities setting up crisis centers. We have seen over 2,000 veterans. I have been at each one of those crisis centers and I can tell you that it is bad and I am deeply saddened. The American Legion is saddened. We is listened to veterans and widows and children who, one by one, told their stories of broken promises, pain, mistreatment, delays, and, yes, even death. Many of them full of hurt, anger, confusion, and uncertainty just want to be heard, yet they have told their stories many times, but their pleas have fallen on deaf ears. During this town hall meetings, The American Legion listened, because what those veterans and family members have to say is important and we want to help. It is woven into the very fabric of who we are as an organization.

I am going to tell you about a man in Fort Collins, Colorado, who spent his last \$40 on a cab ride to get to an American Legion crisis center because he literally had nothing left. I met a widow in Phoenix, Arizona, 70 years old reduced to sometimes sleeping in public bathrooms because the VA couldn't get her DIC claim correct. They came to us in tears. We were able to put her in front of the VA and get those errors fixed on the spot in our crisis center. In El

Paso, Texas, within the first three days, with 74 veterans, we recovered \$462,000 on the spot for those veterans who were entitled to those monies.

I read a letter from the Office of Special Counsel about the VA and the harmless errors that included a veteran waiting more than eight years for a psychiatric appointment: eight years. We have veterans taking their own lives. Twenty-two veterans a day, here in America, and it is a harmless error that a veteran has to wait eight years for an appointment?

We saw in North Carolina a veteran who had been working on his claim for 14 years. As he left the crisis center he said, "I can't believe it took me 90 minutes to fix what I have been working on for 14 years."

That is what we have been doing. Five cities and we have a half a dozen more scheduled. We are making the extra effort; that is what it takes. We all heard whistleblower talk about—talk to this committee about the boxes of mail languishing in Pennsylvania. "You can identify that mail," she said, "it just takes a little extra effort, but they don't allow you to make the effort."

If an employee wants to make extra effort to help veterans at the VA, that employee shouldn't have her car vandalized and be subject to harassment. You need to promote that kind of employee. I hope the VA is listening. I how about you take the whistleblowers, you know, the people with the guts to stand up and say, "That is not the right way to treat veterans," and put them in leadership positions so they can be the example for the people who work for them? You can make some room for them by getting rid of the ones who covered up veterans waiting for care so they could earn a little extra money every year or overstate accuracy to look good.

I want to be perfectly clear, though. This is not about tearing down the VA; it is about saving the VA. The American Legion wants a good VA for all veterans. Abraham Lincoln said, "To care for him who shall have borne the battle, for his widow and his orphan." I didn't read the part that said that is null and void if that affects your bonus.

Who talked to veterans in every city who wanted VA, a place that belongs to them. They want doctors and medical professionals who understand that what—their service and understand their needs. When The American Legion says the VA has a problem with access and accuracy and leadership, we don't want to throw out the VA; we want to help restore it and make it what it should be for veterans, make it what veterans deserve.

The man I told you about in Colorado, he had been let down by the system. The system was supposed to care for him. He was broke. He felt broken and he spent his last \$40 on a cab ride to get The American Legion crisis center. All of his worldly positions on his back in a knapsack, he arrived at the crisis center after it closed that day, so he had to sleep at a gas station waiting for us to open. The next morning we were able to get him in front of the VA and that gentleman was placed in a housing program and received the services that he really needed.

Our chairman of veterans affairs and rehabilitation for The American Legion was so affected that he gave that gentleman back his \$40 because The American Legion truly believes that no vet-

eran should have to pay for services they have already paid for by virtue of their own service. We have served over 2,000 veterans through these crisis centers and life-changing decisions have been made, and we appreciate the support and collaboration of the VA. Those VA employees came into the crisis centers and worked with veterans and they did a great job. This is what happens when we all come together and do what we know is right.

And while we as an organization have been honored to help, the question still remains: Why did it have to come to this point in the first place? Thank you for listening.

[THE PREPARED STATEMENT OF VERA JONES APPEARS IN THE APPENDIX]

Mr. BILIRAKIS. Thank you, Ms. Jones. Thank you so much for that testimony.

Now, I will recognize Mr. Gallucci for five minutes, sir.

STATEMENT OF RYAN M. GALLUCCI

Mr. GALLUCCI. Thank you, Mr. Vice Chairman, and Ranking Member Michaud and Members of the Committee, on behalf of the Veterans of Foreign Wars, thank you for the opportunity to testify on the state of VA care and restoring trust in the VA system.

The allegations made against VA are outrageous and our members are rightfully outraged, plus the VFW worries that the loss of trust among veterans has the potential to be more harmful than some of the impropriety that we have seen. When the scandal broke, the VFW worked quickly to intervene directly on behalf of veterans. We advertised our help line, 1-800-VFW-1899, where veterans could turn for assistance or share their experiences. We also conducted a series of town halls and directed surveys around the country.

And over the first two months of our outreach, we received more than 1,500 comments, most of which were negative. The VFW then worked with VA leadership to help resolve more than 200 critical issues. Next, we sorted through this data to identify trends and make specific recommendations to fix the system.

As we seek to resolve these issues, we must be careful not to dismantle VA or abdicate VA of its responsibility to care for veterans. VA care is far too important since many of its services cannot be duplicated civilian-side. My full comments are submitted for the record.

Today I will share specific concerns on scheduling, non-VA care, and accountability. The major issue facing the VA Health Care System is timely access. Even veterans who relayed positive experiences to VFW still shared concerns over unreasonable wait times. To date, to the VFW outdated appointment scheduling technology is central to the access issue. VA knows that its antiquated patchwork system allows patients to slip through the cracks and makes it nearly impossible to manage clinician workload. This is why the scheduling system is rife with fraud and manipulation and why veteran care suffers.

One veteran who contacted the VFW shared his problems transferring into the Salt Lake City VA system. At first, VA said it would take six months to see primary care. After six months, VA

told the veteran it would be another six months. Six months later, when the veteran called VA, he was informed that he was disenrolled since he had not been seen in more than a year. We have to do better than this. This is why Congress must provide VA with the resources to—necessary to acquire a modern and sustainable appointment scheduling system.

Next, the VFW acknowledges that VA must fully leverage its non-care authority; however, VA must have the responsibility and resources to properly coordinate and deliver non-VA care, otherwise, veterans will suffer. Earlier this week I spoke with a veteran caregiver in Missouri who recounted a recent nightmare receiving non-VA care. The veteran needed a seemingly routine knee surgery, but VA was backlogged and had to send him on the economy for the procedure. What followed was a bureaucratic mess. After the outside provider performed the operation, the veteran was quickly discharged and told that the hospital had no further responsibility, meaning the veteran and his caregiver had to drive directly to VA to receive proper medication and prosthetics needed for recovery.

Now, the VFW understands that the VA may have been best suited to provide both, but this was not communicated to the veteran prior to the procedure. Moreover, the caregiver reported that the non-VA facility was inflexible in providing basic assistance to a veteran who was clearly in pain while still in their care. This is a prime example of why outsourcing VA care is not a catchall solution.

Must VA outsource care when they cannot deliver it in a timely manner? Absolutely; however, VA must continue to serve as the guarantor of such care and Congress must ensure that VA referral teams and private networks can make responsible, timely health care decisions.

Finally, we all know accountability is a major problem for VA and a problem that goes beyond executive employees. Secrecy and a low morale seem to be symptoms of a VA culture that focuses on internal processes rather than patients. Veterans tell the VFW that resources are stretched too thin but employees are afraid to speak up and worse, as we have heard today, penalized when they do.

VA has to focus on patients first by changing this mindset. This demands strong executive leadership and strong whistleblower protections. The VFW also worries that the current bureaucracy incentivizes retention of poor-performing employees over termination and replacement, since VA acknowledges it can take up to a year to fill vacancies. If VA cannot quickly hire top talent, we cannot expect VA to fire bad employees. If VA cannot fire bad employees, we cannot expect VA to deliver timely quality care to the veterans who need it.

Thankfully, not everything the VFW hears about VA care has been bad. Nearly 40 percent of the veterans who contacted us praised VA. Just this week, several veterans sought out our professional staff at our national convention to share how VA doctors had saved their lives. Others offered perspective on how the system has improved over the years. We believe the system can work, but it cannot work without Congress taking action.

This week at our national convention VFW members also passed a stern resolution calling to pass the VA Access and Accountability Act. Both chambers have already agreed that these reforms will help veterans receive timely care which is why our members insist that Congress absolutely cannot go into the August recess without passing this bill. When the current scandal broke, every legislator in Washington agreed that this was a national imperative; however, some have recently backed off, it is post caring more about costs than the veterans who are waiting for care.

We have an opportunity here. We have an opportunity to show our veterans and those still serving in harm's way that our nation will live up to its promise to care for those who defend it. We have to get this right. We have to restore trust and confidence in the VA system and the VFW will do whatever it takes to make that happen.

Mr. Chairman, Ranking Member, Members of the Committee, this concludes my testimony, and I am happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF RYAN M. GALLUCCI APPEARS IN THE APPENDIX]

Mr. BILIRAKIS. Thank you, Mr. Gallucci.

And now I will recognize Mr. Blake for five minutes.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you Vice Chairman Bilirakis, Ranking Member Michaud, Members of the Committee. On behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

You know, it is truly frustrating and disappointing to see the things that have been reported about the VA Health Care System in the last several months, and yet not a thing we have heard is surprising. PVA members, veterans with spinal cord injury and dysfunction, are the highest percentage users of the VA health care system in the veteran population. I can promise you that our members are experienced the long delays and the appointment scheduling gimmicks have that been disclosed.

I am a regular user of the VA. It has happened to me as a regular user of the VA; however, we have fortunate because VPA, 30 years ago, developed an agreement with the VA to allow us to do annual site visits to fully understand what goes on in the SCI system of care and to ensure that adequate staffing and adequate resources are devoted to that system. The sad reality is that veterans who try to access the larger VA health care system do not have that luxury.

The fact is that we are all responsible for these problems. Veterans service organizations should have provoked greater examination of our concerns by encouraging Congress and senior VA leadership to examine the face of these problems as we saw it. Meanwhile, the administration should have been fully honest about the resources and staffing needed to meet actual demand on the system; not manipulating demand data and statistics to make things look better than they obviously were. Finally, Congress should

have actually listened to what we had to say as advocates, and as we have been saying for years.

These access problems can be traced all the way back to 2003 when the VA had to actually begin denying enrollment to eligible veterans who were seeking care because it did not have the capacity or the resources then. Unfortunately, instead of taking meaningful steps then, we allowed the VA to just close its doors to some people and now it has simply got worse, and so here we are today talking about this problem.

In a meeting recently, a member of congress told several of us in the VSO community, "We thought we were giving the VA enough resources." That is a ridiculous statement. This just affirms that no one is listening to what we, the VSOs, and particularly the co-authors of the Independent Budget, have to say because we have been pointing to these problems in both our budget and policy recommendations for 28 years. In fact for years now, we have not once had the opportunity to formally present in front of the MilCon/VA Appropriations Subcommittee to outline our concerns—for years now.

I will not dispute the fact that the VA health care system has been given large sums of money in recent years and that the VA has done a poor job of managing and spending those resources; those are facts. But that does not automatically mean that additional resources are not needed now. We believe they absolutely are, whether to address the recommendations made by the VA or the Administration or the White House or whoever made the \$17 billion recommendation, or to address legislation that the conference committee is currently wrangling over right now.

Unfortunately, the discussion was turned more towards using private health care to resolve these problems instead of restrengthening the VA from within. Sending veterans out into the private marketplace may alleviate the serious pressures on access right now, but that is not the answer to the long-term problem. The VA has provided its appraisal, and yet some Members of Congress have laughed that off as being unacceptable or not part of this debate.

When will it be part of this debate? Because I am convinced that it will never be a part of this debate. Is Congress not really interested in fixing the VA from within?

I hear all the discussions about culture and I couldn't agree with anyone more. The culture needs to be fixed. I use the VA, so I know what the culture of the VA is like, but I can tell you that I prefer to go to my VA doctor.

The question was asked at this committee hearing last week about the possibility of VA contracting out for most services, non-specialized care or care that is unique to the VA. But that question ignores the fact that primary care is not a generic function, particularly when it comes to veterans. Even the representative from the American Hospital Association sat right there and admitted that they would need time to understand the nature of the veteran patient population before they could actually begin to truly meet demand.

Meanwhile, one of the other representatives who sat right here in this seat said, "We have longstanding concerns about the rates

of reimbursement.” Are we not concerned when the people that it seems that we are going to turn to, to help us address these access problems, will readily admit that they fully do not understand veterans as patients and that they are worried about how much they are going to get paid? Their motivations are not our motivations. Their mission is not the mission of the VA.

To be clear, PVA finds it wholly unacceptable that tens of thousands of veterans have waited for far too long for care and in many cases are still waiting to be seen or have never been seen. Not a single veteran should have to wait for care when it is needed and it is incumbent upon this committee, all of us at this table, and the folks sitting behind me to get this right because it will matter in the long run to millions of veterans. So it is time for the rhetoric to stop.

Thank you, again, Mr. Chairman. I would be happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

Mr. BILIRAKIS. Thank you, Mr. Blake. I appreciate it.

I will now call on Mr. Violante. You are recognized, sir, for five minutes.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you, Vice Chair Bilirakis and Members of the Committee. Thank you for inviting DAV to testify today.

When the allegations of secret waiting lists came to light we were outraged, but like you, we wanted to wait for all of the facts before reaching final conclusions. Today there is no longer any doubt that the serious problems uncovered by this Committee and validated by VA’s OIG are real and must be corrected.

Over a decade ago, VA faced similar crisis. In May, 2003, a Presidential Task Force, or PTF, appointed by President Bush reported the following, and I will quote from this book, “As of July, 2003, at least 236,000 veterans were waiting six months or more for first appointments or initial follow-up, a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide required care,” end quote. The PTF concluded there was a mismatch in VA between demand for access and available funding.

As Mr. Michaud pointed out earlier, at a hearing here in February, 2004, Secretary Principi sat at this table and stated, “I asked OMB for \$1.2 billion more than I received.” One year later, after stating unequivocally that VA’s budget for fiscal year 2005 and 2006 were sufficient, Secretary Nicholson admitted VA needed an additional \$975 million for 2005 and \$2 billion for 2006.

Even when VA accurately indicates its needs, OMB passbacks, a lower number in the final budget. That is why DAV and our IB partners have testified over the past decade that VA’s medical care and construction budgets were inadequate. In the prior ten years, the funding provided for medical care was more than \$7.8 billion less than what the IB recommended. For next year, we project it will be \$2 billion less than needed.

Here is what the Congressional Budget Office said in a recent report, and I quote, “Under current law, for 2015, and CBO’s baseline

projections for 2016, VA's appropriations for health care are not projected to keep pace with growth in the patient population or growth in per capita spending for health care, meaning that waiting times will tend to increase," end quote. In addition, over the ten years the funding appropriated for construction has been about \$9 billion less than what was needed and that is based on VA's only internal analysis.

Mr. Chairman, in 1905 American philosopher, George Santayana, famously wrote that, quote, "Those who cannot remember the past are condemned to repeat it," end quote. The question is: Will we learn from the mistakes of the past?

In our view, the debate over whether there is a mismatch between demand to VA health care and the resources provided is a settled issue. Why else would the House vote 426 to 0 and the Senate vote 93 to 3 for legislation to expand veterans access to health care that CBO estimated could cost \$30 billion for two years of coverage and up to \$54 billion annually after that if there was already enough money.

Acting Secretary Gibson testified about the progress made over the past two months, adding more clinic hours, filling physician vacancies and using temporary staffing resources. Secretary Gibson also testified that in order to continue this expanded access initiative for this year and the next three years, VA will need supplemental resources totalling \$17.6 billion. Unlike the proposals in the conference committee, VA's proposal would have an immediate impact by continuing VA's expanded access initiative and its purchase care while building up internal capacity for the future. For these reasons, we support the supplemental request approach.

Mr. Chairman, DAV, has for decades said the funding provided to VA was inadequate to meet current and future health care needs for veterans. Sadly, history has proven us correct. It is up to Congress and the Administration to take steps necessary to end the mismatch, provide VA the resources it needs and work with VSOs to strengthen the VA Health Care System so enrolled veterans receive high-quality, timely, and convenient medical care.

That concludes my testimony. I would be happy to answer questions. Thank you.

[The prepared statement of Joseph A. Violante appears in the Appendix]

Mr. BILIRAKIS. Thank you, sir.

Mr. Weidman, you are recognized for five minutes.

STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Thank you very much, Congressman, Mr. Vice Chairman.

We are a simple bunch and our legislative agenda for the 112th Congress and for the 113th Congress consisted only of four things. Number one, fix the VA. And what we meant by that was gobbledygook that meant nothing in terms of adding to accomplishing the mission.

Secondly is that there be true accountability. When people lie they get fired. If I lie to our National President John Rowan, I am toast, and I absolutely agree with that decision. You cannot run an

outfit where people systematically and unblushingly do not tell the truth.

The third thing is that they have adequate resources, and I have to agree with my colleagues here, is we have been saying for a long time that they don't have adequate resources.

And lastly on our agenda is addressing toxic wounds which hasn't really been adequately done for any generation. It wasn't done for those exposed to ionizing radiation at the end of World War II or during the 1950s. It wasn't true of Vietnam vets with Agent Orange and other toxic exposures. Not true of Gulf War vets who were exposed to sarin, low levels of sarin gas and others which, in fact, do have long-term health care consequences and they haven't addressed that of the young folks today.

It is something that needs to change in the system and not an add-on, but change in the way that VA approaches their mission of veterans health care. It is not a general Health Care System that happens to be for vets. It has to be based on military exposures, whether that be all the things that people talked about here earlier today in terms of spinal cord injury, visual impaired and blind services, prosthetics, and on and on and on, and certainly toxic exposures, and that is why we have such high cancer rates.

I noticed that somebody, and it wasn't us, put it out on the table, a little card from the American Academy of Nursing. And where they get this from, the information in this, they are disseminating it to their members. Why? Because VA is not talking to private sector medicine about the wounds, maladies, injuries, illnesses and conditions that stem from military service based on branch of service, when did you serve, where did you serve, and when and what was your military occupational specialty, and, in fact, it should be because 70 percent or 60 to 70 percent of veterans don't go anywhere near a VA hospital and more would and more do today than did 20 years ago because the care is better, frankly, once you get in.

But we still don't have the adequate resources and most importantly, we don't have the right kind of attitude. The plantation mentality of "we are going to tell these poor vets what they need"—no. How about asking the vets, What do you need? What do you all think? Here is the problem, can we solve this together? Not just at the national level, but at the VISN level, that work level, and at most importantly, we believe, at the VA medical center level.

All too often people have it all backwards. I will use one example. The White House mandated that everybody do a summit on mental health last August and September, so they did it. And they were supposed to meet with stakeholders in the community, including all the VSOs and set the agenda and work together to hold the summit.

Well, that is not what happened. They had a pre-determined message. They invited a couple of people from each VSO and told us what we ought to think. That is not a summit. That is not a partnership. And once we change this at the local level, then we will start to turn it around.

I will say that under the acting secretary, there is a—winds of fresh thought are wafting through 810 Vermont. It hasn't gotten out to the field yet, but it is wafting through. And so people are

doing what they should have been doing all along. Not that we call the shots from VSOs and other stakeholders, but that they ask our opinion.

As an example, on the scheduling system, some people weren't going to ask our opinion and the acting secretary made them listen because we know what it is like because it is our folks who go through the nonsense. And if you want to change a VA, you change that particular part of it. Forcing VA to listen to the stakeholders and to really do patient-centered care or veteran-centric care. And to do that, you have to respect the individual veteran and the veterans organizations that—and other stakeholders.

I want to just touch on resources here for a second. We have said from the outset that the Millman formula imposed in 2003 was no daggone good. Why? Because it is a civilian formula that is designed by Millman for PPOs and HMOs and middle-class people that can afford those. That is not who uses VA.

The average number of presentations at that time was five to seven presentations of things wrong with veterans coming in the VA hospitals, and today, among the youngest vets, OIF/OEF, it is 14 presentations. But the Millman formula figures on one to three presentations. Now, it doesn't take a rocket scientist—even I can figure out that you are going to fall further and further and further behind if you use that to estimate what the need is going to be. We need to junk that and go to a more realistic funding based on the needs of the people in the catchment area.

The last thing I want to comment on, and as an appendix to today, people have been saying, where are we going to find the medical professionals? And a number of people inside, particularly those within the AFGE, have been working on a program called "Grow Our Own" and it is based off the old medics program, and not just for former medics and corpsman to become physician assistants, but why not send them to school, even if they are smart enough to go to medical school and they give back two years for every year that they are in school. Then you are growing your own. It is veterans who have served and who are committed to the system from the heart outward and we will have enough people for the future.

And so I recommend that to the Committee. I thank you for the opportunity to appear here today and thank you for your indulgence because I see I am over.

[THE PREPARED STATEMENT OF RICK WEIDMAN APPEARS IN THE APPENDIX]

Mr. BILIRAKIS. My pleasure. Thank you for your testimony, sir. Now we will recognize Mr. Nicholson for five minutes.

STATEMENT OF ALEX NICHOLSON

Mr. NICHOLSON. Vice Chair Bilirakis, Ranking Member Michaud, and distinguished Members of the Committee, on behalf of the Iraq and Afghanistan Veterans of America, we appreciate the opportunity to share with you our views and recommendations on what changes and reforms should be made to the Department of Veterans Affairs and on VA communication and collaboration with veterans service and advocacy organizations.

In recent months, revelations about extensive patient wait times, a manipulation of data, a systematic lack of accountability, and even preventable veteran deaths within the VA system have undermined the trust of the American public and our VA and it has had a particular impact on the trust and confidence of IAVA's members in the system. While it is true that many of our members have expressed general satisfaction with the quality and delivery of health care they receive from VA, many have also expressed serious frustration with general access to and direct communication with the VA system.

IAVA is pleased to see some recent changes within the VHA, but we are eager to see more structural reforms pursued in the areas of accountability, the adoption of best technologies, and increased capacity to deal with future needs. Congress has acted swiftly in the area of accountability and response to the systemwide VA scheduling scandal by passing the VA Management Accountability Act. We are pleased to see this legislation move forward, but our members want to ensure that the secretary actually uses it once it is signed into law.

We would even welcome an extension and application of similar authority to Title 38 and GS employees, as well, within the VA with appropriate due process protections, of course, as a part of that. IAVA would also like to see VA adopt not only new, more user friendly technological platforms, especially those that are veteran-facing, but we believe the organization needs to begin a shift in the way it looks at its technology needs and how it goes about acquiring and/or designing those systems. Compared to the private sector user interfaces that our members use, the VA's web-based platforms and portals are frankly a joke to many Iraq and Afghanistan-era veterans.

Finally, our members want to see an increase in VA's capacity to deliver critical services to veterans, especially in the realm of mental health care. The shortage of psychologists, psychiatrists, counselors, case and social workers, and other mental health professionals and service and support staff must be quickly remedied. Some of these, and more other reforms and actions are actions the VA could have pursued at least partially all along. Unfortunately, the VA's level of communication, cooperation, and collaboration with new generation organizations like IAVA over the past five years has been severely lacking. In fact, prior to the outbreak of the VA scandal, the current VA access scandal, the former secretary of veterans affairs had only met with IAVA directly on one occasion during his entire tenure as secretary.

Much like the VA's attitude towards this committee, if the prior regime within the VA did not like what they were hearing from its non-profit partners or those partners refused to toe the party line, they were shut out from top-level access entirely.

VA's interim leadership, however, has been much more communicative with IAVA and other VSOs and veterans advocacy groups, and the new VSO liaison brought on by VA immediately prior to the access crisis, has done phenomenal job in working to repair the relationship between VA and the nation's largest organization of Iraq and Afghanistan veterans and their families.

In addition to the above, we also want to take the opportunity to let members of the committee know that today, right now, the National Press Club, IAVA is releasing the results of its 2014 member survey. IAVA's policies, position, and priorities are driven every year by our annual member survey and the data this year overwhelmingly revealed that suicide and mental health care access at the VA are the top challenges facing this generation of veterans.

More information about the results of our member survey are available today at IAVA.org and our staff and search team, led by Dr. Jackie Maffucci in our DC office would be happy to brief you and your staff on our detailed 2014 findings in the very near future.

Mr. Vice Chair, we appreciate the opportunity to share our views on these topics and look forward to working with you and your staff to improve the lives of veterans and their families moving forward. Thank you.

[THE PREPARED STATEMENT OF ALEX NICHOLSON APPEARS IN THE APPENDIX]

Mr. BILIRAKIS. Thank you, Mr. Nicholson.

Thank you all for your testimony, and I will recognize myself for questions for five minutes.

First question for the entire panel, Mr. Robert McDonald, as you know, has been nominated by President Obama to be the next secretary, permanent secretary. I am sure that we all agree that of course he will face—he has his hands full to restore the trust in the VA. What is your opinion of the president's choice to have Mr. McDonald run the Agency, the Department as the permanent secretary at the VA? Does his lack of experience of running a Health Care System concern you?

And we will start with the gentleman—actually, ma'am, we will start with you, Ms. Jones.

Ms. JONES. The American Legion stands ready to assist anyone that is appointed as the secretary. Whoever the choice is, The American Legion has a history of advocating for veterans and as we stood by the previous secretaries, The American Legion will continue to stand by and to let Mr. McDonald know that we are here to assist him with whatever he needs. The lack of experience—The American Legion has been around since 1919 and we are going to be here to help, as we have always done, whatever veterans need.

Mr. BILIRAKIS. Have you had any contact with Mr. McDonald?

Ms. JONES. I have not, sir.

Mr. BILIRAKIS. Okay. What is one piece of advice that you have for him or an area that you would like him to focus on the most?

Ms. JONES. Transparency. We would like to see more transparency so things like the scandal doesn't happen again; so we know what the VA needs; so we can advocate for those needs, we would like for the secretary, whoever that may be, to let us know what is needed and to be transparent. So as long as we know what we are working with, it can always be fixed. We can work towards making sure that veterans are taken care of timely and that they receive quality service.

Mr. BILIRAKIS. Mr. Gallucci, same question.

Mr. GALLUCCI. Thank you, Mr. Bilirakis.

The VFW has been supportive of the selection of Mr. McDonald, the nomination of Mr. McDonald for the position of VA secretary. We think it is time to do something a little different. We think the expertise that he brings has the opportunity to change the mindset of the VA system.

This goes beyond just VA health care. The secretary is responsible for coordinating the myriad of veterans programs that millions of veterans rely on, whether it is Post 9/11—GI Bill, disability compensation, home loan program, and really think that the corporate mindset might be beneficial for the VA system.

And to one of your other questions about what do we think that the VA should focus on, I think from the VFW's perspective, it would be improved business processes. From what we have seen and from what we have heard from our veterans, we know that the system hasn't been patient-centric when it should be, and that is the VA Health Care System specifically. But we think by improving business processes and streamlining the way decisions are made within the VA system, we can improve the delivery of services to veterans.

Mr. BILIRAKIS. Thank you.

Mr. Blake, please.

Mr. BLAKE. Mr. Bilirakis, we don't typically take official positions on nominees for secretary, but what I will say, having said in the confirmation hearing on Tuesday, I was very encouraged by the things that the nominee, Mr. McDonald, had to say. He certainly addressed the concerns raised by Ms. Jones about transparency a number of times. And I am sure—while he may not have said it to you yet—I am sure that one of the first things he will tell you is he will give all of you his cell phone number and expect you to call him and he will call you at all hours of the night. So he certainly seems to be willing to be actively engaged with the committee, so hopefully that will fix transparency.

I think his first priority ought to be culture. I think the bad actors, the bad attitude, and the bad processes ultimately stem from the culture that is set. I think Acting Secretary Gibson has done a good job of trying to change that, but you can't change that overnight. I think the committees are debating right now—tools. The question was asked about the challenges and certainly Secretary Gibson made it clear that the challenge of firing people is a tough one.

I won't argue with you. If somebody did something illegal, wrong or immoral or whatever, if it somehow in some way harmed the health care delivery for veterans, they should be fired. But that question ignores the fact that Congress put in place federal rules that make that a difficult process. So if Congress thinks that that should be changed, then so be it. I know that the Committee is looking at legislation that will address that issue, but it is going to take a—and Mr. McDonald seemed to be committed to changing the culture and I think that is going to be first in his mind.

Mr. BILIRAKIS. Mr. Violante, again, give me your opinion of the secretary and what piece of advice would you give him?

Mr. VIOLANTE. I was also at the confirmation hearing and I was impressed with his responses to the committee's questions, as well as his oral remarks. I just hope he can accomplish most of what he said. In my mind, the one important thing that he said was transparency, and that, I think more than anything else, we need to see at VA. I don't know that we will ever see it accomplished, but I think it is a goal that the new secretary should try to achieve so that we know what is going on and what needs to be done.

Mr. BILIRAKIS. Mr. Weidman, what should the secretary focus on?

Mr. WEIDMAN. I think the most important goal is what people have already said, and as a means to that, I forget how many hundred communications folks they have over at the central office of VA. They are not in the business of communication. They are in the business of obstructing and obfuscation, and most of those folks need to be assisted in finding another way to contribute to the good of the world and you need two or three really smart press people. Curt—does a better job than all of them put together, who is the PIO for the committee.

And what it does is that things that ought to be on the web suddenly become FOIAs, or Freedom of Information Act, and drag out for months. Example is just asking for job descriptions of major positions within the VA, which happened to me last year. It took me five months to get the darned thing. I had already gotten it another way, but—and one of them, they said they didn't have because it wasn't available in 810 Vermont Avenue and that was the job description for the director of the national center for PTSD.

You don't have a job description? How could that be? And, of course, it wasn't, but you had some attorney who could be put to use enabling veterans to get their claims approved, as opposed to messing around with bureaucratic junk. And that should be the litmus test, certainly for everybody in VHA, is how much do they and how much do they contribute to accomplishing the mission. And at VHA, all of those middle people, almost all of them, need to go away because they just get in the way of the mission.

Mr. BILIRAKIS. Mr. Nicholson, last question: Again, does it trouble you that Mr. McDonald lacks the health care management experience?

Mr. NICHOLSON. It does not necessarily. I mean he has a phenomenal business background, and like I think Ryan mentioned, business processes is something that I think, you know, the VA certainly needs some focus on. IAVA is supportive of Mr. McDonald. We were not consulted by the White House on the selection process or the nomination, but he was sort of an out-of-the-blue pick for us so we had to do a lot of catching up in learning about him and still are in the process of that, as is everyone else, I believe.

But we are generally supportive of him. I mean we would agree, I think, that accountability and transparency are top priorities, but also tech upgrades, as well.

Mr. BILIRAKIS. Thank you very much. I yield back—

Mr. WEIDMAN. Mr. Bilirakis, can I add just one thing?

Mr. BILIRAKIS. Yeah.

Mr. WEIDMAN. Earlier I noticed in the audience the Honorable Harry Walters, and when he took—came in in 1982, the veterans

organizations were so mad that everybody was chewing on nails. And he came in as a businessman, no experience, and took over the VA, restored confidence in what they were doing, and straightened out a whole lot of problems, including assisting Vietnam veterans truly for the first time. So it is possible, with a background, to be one heck of an administrator at that time, and today we call it the secretary.

Mr. BILIRAKIS. I yield back, Mr. Chairman. Thanks so much.

The CHAIRMAN [Presiding]. Thank you, Mr. Bilirakis.

I apologize to the panel. We were having a conference committee meeting and I would say, Rick, that I will be meeting with Mr. Walters this afternoon at 3:30 to gain some insight from his time as the administrator.

Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

And before I ask my questions, I do want to commend Secretary Gibson for still being here. It shows that your commitment to listen to the VSOs—I think this is the first time that I have ever seen a secretary sit through another whole panel—so I really want to commend you for doing that. It shows that you are taking your job very seriously as well, and hopefully we will see action as well.

For each of the panelists, as you know, Congress continuously asked the VA about what they need for services. You heard my comments earlier about Secretary Principi was actually the first secretary that really showed that disconnect between what the needs were and what the Administration asked for.

My question is, to each of you—if you could keep it short, it would be great—do we need to do an independent audit to properly plan the VA's budget? My biggest concern has always been—I have made it very clear over the years—is I don't care how big the increase it is within the VA budget, is are we taking care of our veterans? And as you heard the secretary mention earlier it has always been budget-driven and not outcome-driven.

So I guess we will start with Mr. Nicholson first. Should we have an independent audit to properly plan the VA's budget?

Mr. NICHOLSON. Sure. You know, the first thing that comes to mind is in a way we already do. I mean we have the Independent Budget, which many of the VSOs sitting here play a very prominent role in putting together. I know that Carl is sort of our community's budgetary expert and we defer to him on a lot of these issues. But I think it is certainly helpful.

But please keep in mind that we don't have to reinvent the wheel. Please use resources that already exist and give credible weight to those as well.

Mr. WEIDMAN. The VA has reached out to some places like the Mayo Clinic, but, in fact, nobody has really reached out in a systematic way to all sectors of our society. The one thing we do know, when the issue is veterans, people will step up from industry, from the not-for-profit sector, from the medical sector, et cetera, and we need to tap into that in an organized way—and including organized labor, by the way—in a way that makes sense in order to get what we need to get in terms of designing a system that actually can estimate the needs and then put it together in a way where people are held accountable as it moves back down the chain.

Mr. VIOLANTE. I disagree with my colleague, what he—with Rick, what he said earlier about the actuarial model. I mean when we were still pushing for mandatory funding for VA health care, we went in a number of times to talk to the VA budget people and at that time they told us that the model, which was based on a civilian model was revised to, you know, be specific for veterans use.

And I believe if there was transparency in the process and we could see what VA was putting into that model and what comes out without OMB having a shot at it, that we would be better off and know exactly what the needs are. Because that is all we want to know, is what VA needs. I don't care about building an empire for anyone. I want veterans to be taken care of and the only thing that is important is to make sure that their needs are met.

Mr. BLAKE. First, Mr. Michaud, let me say I'm not sure that I want the distinction of being recognized as the community budget expert.

From the perspective of the Independent Budget, what I will say the difference between what we do and what the Administration does is—and Secretary Gibson hit this on the head—managing the budget versus managing the need. We take whatever information we have available to us, look at what the actual need is and figure out what we believe the cost is. We don't take a budget number and try to fix—smash the services down into the available budget that is given. That is what the VA is required to do.

You asked about an independent audit and when we advocated for advanced appropriations, this is one of the ideas that we had wrestled with, was having a type of independent audit of the VA budget. The best we came up with in that legislation I think was the GAO responsibility within that. I am not sure if that is going to get us to where we want, but that is the idea. So I think we agree with what your notion is there and we would like to see it enhanced, perhaps.

Mr. GALLUCCI. I think the VFW generally agrees with that concept and we testified to this effect when the Senate hosted a hearing right when the scandal broke, back in May. And the real problem is we have assessed what VA's workload could be or what their problems are, but as we have learned with the scheduling system, it is software that is decades old and VA, by their own admission, says they have no accurate measure of wait times, no accurate measure of wait lists. Thousands of veterans waiting for initial appointments, based on their independent review that was recently conducted.

So I think right now being able to even evaluate the need is very difficult. I have seen it myself, as my colleague Carl said, he is a patient at the VA. Many of us at this table also use VA for our health care and I have seen it, waiting for a specialty appointment and you call in and they say the next thing that we have is 60 days from now.

Well, what are my options at that point? And that demonstrates to me, as a veteran, as an end user, that there is obviously something missing from here. Either capacity isn't where it needs to be or they haven't fully evaluated what the need is in their community.

Ms. JONES. The American Legion wants all available resources used to make sure that veterans are okay. If that means an independent audit of the budget—absolutely. We want to make sure that there is enough resources, enough of everything so that veterans are taken care of and they don't have to suffer like they are suffering right now.

The CHAIRMAN. Dr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

I appreciate the ladies and gentlemen that are here today. I first want to thank Mr. Nicholson for the whistleblower hotline. I believe that is our association that set that up, and what is stunning to me—I have served on this committee for three years—and we have heard from the VA again and again and usually it was always that things are fine, and then we have whistleblowers step forward.

I am just curious. Were you all hearing that from your associations, from your membership about these secret waiting lists? I never heard that coming from your groups, and so I am just curious on background of how this can happen. You know, I was just looking through the Life magazine article for May of 1970 of how that suddenly burst on the scene. Folks were suggesting that there were problems then and suddenly it happened, but that is—you know, just a few months ago, all of a sudden, boom, here it is.

And in this committee we have heard warning signs from folks inside, but we will talk a little bit about the budget question. But first question, what you were hearing from your members and did that match up with what the whistleblowers had reported to us?

Mr. BLAKE. Dr. Huelskamp, I will say, as I mentioned in my oral statement, the one luxury that we have from PVA's perspective is our site visits that we conduct. So we don't necessarily have to just rely on what we hear from our members. We have trained medical staff who go into the SCI centers and see what is going on there and they see firsthand where the shortages are; where there is a need for doctors; where there is a need for social workers, nurses or what have you.

The difference between what has happened with this and what we do is we have an agreement with VA and we worked those differences out to come to a resolution that will benefit the veteran. This is all sort of played out more in the public eye, which is fine in as much as maybe by drawing attention to the larger problem, we get real reform and real fixes. But these, again, are not shocking.

We have seen these. We have identified them in our site visits—

Dr. HUELSKAMP. But the secret waiting list, I mean here is what I saw at one facility. We had the director of the VA at the VA facility in Wichita on a Friday said everything was fine, and then within five days they admit that they had secret waiting lists they knew about. And so my question is—and I can't go look through the data.

Are you going through looking through the data and actually talking to the schedulers? Because this is the thing: They went in and falsified the data and then presented it to us.

I am trying to see how we can have you continue to help with these visits and how far you can dig into that to help, enjoy, provide some more transparency.

Mr. WEIDMAN. We have been complaining that they were underresourced all along, and certainly to the former under secretary, that you are spending way too much money on people who aren't direct service providers. Congress—we are not speculating that that is why Congress gave you more money; that is exactly what the appropriators told us they were giving us money for, was more people who were hands-on delivery of service and you guys are spending on people who never lay a hand on a patient.

Dr. HUELSKAMP. Sure. Sure.

And, again, I appreciate that because we get reports, and, again, if you heard on the other panel, in the last month, every single bureaucrat from the VA, every under secretary, every bureaucrat came here and said we have plenty of resources; it is a cultural problem. It is how we are spending them. And so either they are totally wrong or you are totally wrong and we are trying to figure out what we can do about it.

But what Mr. Gallucci said at the end was very interesting because, you know, how, as policymakers, when the data is unclear, there is a lack of integrity, how are we supposed to make a decision to give more money? In the past decade, roughly, it has been a 250 percent—256 percent increase, meanwhile the number of veterans are 30 to 40 percent. And trying to say, well, why didn't I get an MA? That is what is happening. It went to overhead, rather than direct care.

But what is frustrating to me is when they lie about the data. They make it up or they refuse to be transparent so we can't make good decisions and then we hear from the top-level folks that say the way the Union rules work, we can't get rid of somebody until we get all of the facts, and right now we don't have all of the facts when the claims are that we need more money. We want to make sure that that happens.

One of the other things we heard, which is interesting: Why can't they stay open until five o'clock? Why can't they do that? You mean to tell me that they all go home at 4:30? Why not five o'clock? We just had that report would fix and add additional resources without making significant changes. Those are the kind of things that make sense. Appreciate your input, but I appreciate particularly the whistleblowers who are bravely shown up and said, Hey, we are going to tell you what is happening here so we can improve the system.

So with that, Mr. Chairman, I yield back.

Mr. VIOLANTE. I would just like to make a comment about the fact that secretaries come in here and they say they have sufficient funds or under secretaries. You know, I have been doing this for a long time, and with the exception of Secretary Principi who said that he got less, I mean most of the time that is what we hear. And, you know, other than three years during the Clinton Administration when they were flatlining the budget, Congress agreed with those numbers.

Up until recently, I mean Congress has always provided more than what the Administration has asked for. You know, they are

part of a team and while it is frustrating to hear them say they have the resources, I mean I don't think they would be in their position very long if they told you, as Secretary Principi did, and at that time we were asking for over \$3 billion more when he said that he needed 1.2.

So I would be a little bit leery of asking them that question and expecting an accurate response unless you put them under oath, but I mean it is just a concern.

The CHAIRMAN. Mr. Violante, are you saying that Secretary Principi, in fact, did tell the truth?

Mr. VIOLANTE. I am saying that he admitted that he asked for more. What I am saying is at that time we were asking for almost twice that amount for VA's needs.

The CHAIRMAN. So would you say the other secretaries were not being truthful? This is just Mr. Violante.

Mr. VIOLANTE. I mean they are not under oath, so——

The CHAIRMAN. They can tell the truth whether they are under oath or not.

Mr. VIOLANTE. Yeah, but when have you heard anyone admit to you as part of another team that they didn't get what they asked for, other than Secretary Principi.

The CHAIRMAN. Okay. So Mr. Violante said the other secretaries lied. Thank you, sir.

(Laughter)

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Violante, I think I understand what you are saying. I mean I used to be on a board of trustees and, you know, all of the administrators all come to me and they all kind of toe the administration line. It is not a matter of lying or not lying; it is a matter of that is just the way it is in the administration. And that would be true of a Republican or Democratic Administration, you would want loyal people underneath you.

So, you know, real quickly, you can almost answer yes or no, would you say that your organizations and your members basically want to mend, not end the VA, Ms. Jones?

Ms. JONES. Yes, we want to restore the VA and restore the veterans' trust in VA.

Mr. TAKANO. Thank you.

Mr. GALLUCCI. We absolutely want to restore trust in VA and build a system that has the capacity to care for the needs of veterans.

Mr. TAKANO. Mr. Blake.

Mr. BLAKE. Yes. Our members want the VA.

Mr. VIOLANTE. We want to save the VA, but fix it.

Mr. NICHOLSON. Absolutely. We are all in favor of mending and not ending the VA.

Mr. TAKANO. Let me just turn the other way starting with you Mr. Nicholson. Mr. Nicholson, does your organization support the 17 billion supplemental requested by the VA on top of, you know, recently with Secretary Gibson?

Mr. NICHOLSON. Sure. IAVA certainly supports giving the VA more resources and believes that it does need more. Whether or not 17.6 or 8 billion is the exact number, I don't know, and I don't be-

lieve we know. Our concern with the number is just making sure that it is well-justified, but making sure that the VA is well-resourced is a primary concern.

Mr. TAKANO. I have a short amount of time. I just want to know in general, I mean, if that is something that is on the table, if you are supportive or not, Mr. Weidman?

Mr. WEIDMAN. The 17.6 number we are not going to defend because we have no idea how it became that. The point is that really—from our point of view—how much is asked for and how much additional is appropriated; it is tracking how it is used.

You remember when it was in 1999, \$319 million appropriated specifically for Hepatitis C and a year later, they couldn't tell you what the heck happened to the money.

Mr. TAKANO. Great. Thank you.

Mr. Violante.

Mr. VIOLANTE. We support the approach of supplemental versus what is going through conference.

Mr. TAKANO. Great. Thank you.

Mr. BLAKE. I can't say for sure whether \$17 billion is the appropriate number. I can tell you what the IB has done over the same period of time. I think the idea of strengthening the VA through more doctors and more nurses and that type of thing is part of the approach that needs to be taken.

Mr. TAKANO. Thank you.

Mr. GALLUCCI. I would agree with a lot of what my colleagues have said. It is not necessarily about a dollar amount, but what we do support is providing VA the resources that it needs if they can demonstrate that they need it.

And like I mentioned before, just as end users of the VA, it seems clear to us and from what we have heard from our members, that something is needed.

Mr. TAKANO. Sure.

Ms. JONES. The American Legion supports veterans having what they need, but we don't have enough information right now to support or not support.

Mr. TAKANO. Okay. I take that information very, very—I appreciate it. I see the conference as fluid and, you know, we need to really get down to the business of finding out what that appropriate number is.

Now, the shortage of doctors is something that I have been very much concerned about. I am most skeptical about an approach which only funds non-VA—access to more non-VA care is the solution. I think it is part of the solution. I am skeptical of us being able to find that there are shortages in many communities that even this access to non-VA care is not going to work unless we increase down the line, a supply of doctors.

Mr. Weidman, I appreciated your sense of let's grow our own, but even if we send these medics to medical school, we are still frozen at 1996 levels of graduate medical school education; the education that is basically what we would call residencies.

Would you all consider supporting the expansion of, you know, we have—Dina Titus has a bill that would expand residencies by 2,000 and let the secretary designate where our greatest need is, especially in, say, mental health care?

Mr. NICHOLSON. You know, IAVA would absolutely support anything that increased capacity at VA, but I think the important thing to keep in mind is those are going to be intermediate to long-term solutions. It takes awhile for someone to go through residency. It takes awhile for recruitment to happen and for those folks to actually become practicing physicians or providers within VA.

The support for private sector care is intended to be a short-term solution to address the crisis going on right now and that is why we strongly support that. I don't think that it has to be either/or. One is a short-term solution and one is—

Mr. TAKANO. I agree with you. I think we need to support non-VA access. I understand that we have 2,000 medical students presently that aren't matched with residencies. We actually have people in the pipeline here who could begin their residencies right now.

Mr. Chairman, I am sorry. I ran out of time.

The CHAIRMAN. Thank you, Mr. Takano.

If I could just ask a question, you know, because every one of you answered, and this is an issue that has been thrust into the middle of the conference committee and that is the \$17.6 billion request. It is not even a request, okay. It is not. It is an unfunded list.

With all of your resources and all of your people and all of your expertise, you sit here today and you tell me exactly what we are saying, is there is not enough clarity to know whether or not this is a good request or a bad request, too much money, not enough money. And I don't think that you have heard a single member of this committee say that they are not willing to fund what is necessary.

So I just, you know, I want to make sure that folks know that nobody up here is trying to tear the VA down. We are trying to get the VA to serve the veterans that each of you represent and I hope you understand that. But there was a letter that was signed yesterday and while you may not have intended for it to say that you supported the entire 17.6 billion, you put the full weight of support of your folks behind that in the middle of very tenuous negotiations between the House and the Senate. We just went over and made a very prudent offer. Unfortunately, the Senate Democrats were not there. You guys, thank you for holding the fort back here and covering. Mrs. Kirkpatrick was there.

And I think the reason that we did it the way we did it was we have not had a public meeting for four weeks and our intent was to publicly say that the House's offer—I say the House—my offer, was not cheap on the money in regards to what CBO had scored. Just so you all know, the offer was, to take up the Senate Bill, pay for it by putting \$10 billion in emergency funding mandatory up front, a good solid down payment. And also we said extend that 10 billion out as long as it will go because I don't believe they will spend it in a year. I just don't think they will do it. I think it will actually go into the second year.

And for the second 25 billion, we go through regular order, which is, Rick, exactly what you were saying just a second ago. You know, oversight, what is it for?

Each of you, probably not on purpose, has said, we need more docs; we need more this; we need more that. But I haven't heard—and you may have said it before, maybe in your testimony—look for

efficiencies within the system. There are inefficiencies in the system, whereby doctors are only seeing six, eight, ten patients a day. That is not enough. Mental health providers that are only seeing patients two hours out of a day, as my colleague has said, expand the office hours so the infrastructure that is already in place can be used to supplement the doctors that are there.

So we are all in this trying to work together and we said let's do the \$25 billion through the normal appropriations process and look, we are right now negotiating—well, I don't know—has the Senate passed their vote on the VA appropriations bill?

The CHAIRMAN. The Senate hadn't even passed a VA bill; the House has. But we want to begin negotiations, and if we need to interject additional dollars, that is where we should do it. It is not that we don't necessarily think that the money may not be needed, it is we don't know and you don't either. So we are asking for clarity from the VA—the secretary and I have talked about it—two pages of documentation for a \$17-and-a-half-billion request.

And then we have an under secretary come here yesterday and when asked particularly about the request, she didn't know how to answer it. She says, "Whatever they are calling it." We can't work that way. You wouldn't want us working that way. You couldn't do your jobs working that way. We have to know what the money is going to go for. What it is being benchmarked against so that we get this right.

This is not a partisan issue. It is not partisan. Mike Michaud, the other members on the democrat side and all of the Republicans have done everything that we can to make this a bipartisan issue. I have tried not to walk too far out in front of my ranking member when it comes to subpoenas or letters or anything that I do, as the chairman of this committee. And if he is comfortable signing something, I ask for his signature, and if he is not comfortable, that is just fine, not a problem. Because we do come from different districts, we serve in different caucuses, and I get where that comes from.

But all of a sudden this morning, it is being said in the press that this has evolved into a partisan negotiation—no, it has not. No, it is not. It is an American negotiation. It is for the men and women that you serve. It is for the men and women that we serve. We cannot fail them and we cannot get it wrong. We have to get it right, and sometimes it takes a little longer to get it right, but we are going to get it right. I promise you that we are going to get it right and we can do it with your help, every one of you. Because you have all been great help us to as we have gone through this process.

Mr. BLAKE. Can we comment, Mr. Chairman?

The CHAIRMAN. If I can, let me go to Ms. Brownley. And, again, I appreciate it. That was my five minutes. Ms. Brownley?

Ms. BROWNLEY. Thank you, Mr. Chairman.

And based on what the chairman just said, I think that is a good segway to hear what you have to say in response to some of his comments. It will be my questioning, so I can start from either end.

Mr. BLAKE. Mr. Chairman, I was just going to say I don't think I disagree with anything that you had to say. If we have concern, it is that I am not sure there has been enough focus, other than

on the culture of VA. There has been a lot of discussion about fixing the culture of the VA, and as I said in my statement, I think that is probably the first thing that needs to be fixed.

But I am not sure I am convinced that there has been much of a discussion about what to do about the capacity problems in the VA.

The CHAIRMAN. Will the gentleman yield if you allow him to yield?

Ms. BROWNLEY. Absolutely, Mr. Chairperson.

The CHAIRMAN. Dr. Wenstrup sat right up there a few nights ago and asked, "How much does it cost the VA to serve a patient?" They couldn't answer the question. We asked the question, "What is the typical panel of docs—how much does a doc see on a daily basis?" And some people couldn't answer the question.

So, yes, the focus is on doing whatever we need to do and that is efficiencies inside and capabilities outside, and that is why the choice piece may be and you guys—I am going to be real honest with you—some of you thankfully have not gotten really spun up about the choice piece when you could have because a lot of people in the past have said that is a way to tear the VA down. That is not what we are trying to do and I don't think that there is going to be this fleeing out of the system. I think many, many people are going to stay in the system.

And so we have focused, from an oversight perspective, we haven't been able to get the answers that we have been asking for, and I would be glad to share with you the list of information that we have asked for and have not received. The secretary gets it every week.

But I agree, and, yes, there has been a lot of focus on the outside, but there has been focus on the inside, and I yield back.

Mr. BLAKE. And, Mr. Chairman, my one point that I would make about the point that you made with Dr. Wenstrup was about how much does it cost per patient, what the hell is the information that they publish in their budget books? There is a particular line item that says "priority group one" and a cost associated with that patient. Maybe I don't understand what that means, but I interpret that to mean exactly what the question was you asked.

The CHAIRMAN. Then why can't they answer the question?

Mr. BLAKE. I don't know. I could have pulled that number out in a second right out of the budget book.

The CHAIRMAN. You need to go work for VA.

Mr. BLAKE. I would have.

The CHAIRMAN. You need to go work for VA.

Mr. GALLUCCI. From a VFW perspective, we certainly understand everything that you are talking about Chairman Miller, but our members are frustrated. I just returned from our national convention in St. Louis where the membership passed a resolution insisting that Congress pass that bill and send it to the president before the August recess.

And the frustration comes from the fact that this was a major priority two months ago for each chamber to get together, outline its priorities, get them down on paper and start moving on it. And what our members have told us is that they don't see progress. In

fact, what they have seen is a narrative changing where it used to be about caring for veterans and now it is about costs.

The CHAIRMAN. Will the gentleman yield?

Mr. GALLUCCI. I am sorry?

The CHAIRMAN. Will the gentleman yield?

Mr. GALLUCCI. Yes, Mr. Chairman.

The CHAIRMAN. We had a meeting today for the first time in four weeks and the Senate boycotted. We were trying to tell the American people exactly what we were doing; quit trying to negotiate behind closed doors. Do this in public so people know what is going on.

I will tell you this: There has been a tremendous amount of work that has gone on behind the scenes in an attempt to negotiate this, and I think everybody has said the intent is not to leave unless this is finished, and we appreciate the urgency with which the VFW expressed in their resolution, but, again, there has been a lot going on and today we hold a public meeting and the Senate boycotts. I yield back.

Mr. GALLUCCI. Mr. Chairman——

Ms. BROWNLEY. I yield my time to Mr. Walz.

The CHAIRMAN. And I didn't mean to take Ms. Brownley's——

Mr. WALZ. Thank you, Ms. Brownley. We are using your time on this.

Mr. WALZ. This is a bipartisan effort, but—and the chairman and I are friends and he knows me well enough, he knows that nobody does passive-aggressiveness like Minnesotans—so to characterize that the meeting was—as a good Minnesotan, I was actually in bed before notice of that meeting was even put out. And then when I asked this morning about what was going to be put out at that, we weren't given that.

That is not a conference report, Mr. Chairman, and you are a friend of mine, whom I trust.

The CHAIRMAN. Will the gentleman yield?

Mr. WALZ. I will yield to you from Ms. Brownley. This is our time to be honest and——

The CHAIRMAN. I will be very honest with you. All right. Let's go all the way back to the very beginning of how this conference started, all right?

The last conference committee that was held, many of you were probably here in 1999, the Senate chaired that conference, so it comes to the House to chair this conference, all right? And at the beginning of the conference, there was some discussion between myself and Mr. Sanders as to who was going to chair and I said, "Let's be co-chairs, all right, let's be co-chairs."

I asked the senator earlier this week could we do this yesterday and he said nope, didn't want to do it yesterday. All right. We were trying to negotiate all day yesterday, trying to figure out when we could do this and I was told time and time and time again that I better not unilaterally call a meeting.

Now, as the House position that should be the chair of the committee and for Senator Sanders to make a good effort to stop us from having a public meeting, after a good effort from my part to make him co-chair, and sitting down at this hearing, I did share

what the offer was with the chair and I asked him to share it with everybody here. It is not a conference report; it is an offer.

It is on one page. Our offer is on the same amount of paper that VA's justification to \$17.5 billion is on. So it wasn't done as a partisan move.

Mr. WALZ. Was any of that conveyed to us? I mean——

The CHAIRMAN. We met at 9:30——

Mr. WALZ. And I had with the secretary sitting in front of us——

The CHAIRMAN. We met at 9:30. Look, it was an offer. It wasn't intended to be a House offer. It really wasn't, because I know that you can't do that, but it was just to say the House is prepared to put money—\$10 billion has been in the negotiations from probably the second day, hard money.

Have you seen it in the press one time? Probably not. What you see is the House is trying to do it on the cheap. And so it was an attempt to bring it forward and say, look, here is where we are, the House position is that it is difficult to fund any of the \$17.6 billion without more justification. In the offer I think we put 102 million in to finish out through the end of 2014. I will go ahead and notice I wrote a letter to the senator and I asked him, you know, be prepared to meet on Monday. Don't know when and don't know where, but just so everybody knows, we will be back in time, it will be in time for everybody to be back here.

But, you know, what has happened is by negotiating behind closed doors, and we have gotten pretty darned close, you know, this whole thing, I just saw them report it in the meeting a little while ago that this thing is doomed. No, it is not. It is not doomed. As long as we work together in trying to resolve it.

But I didn't want to put you in a position to say you are making us decide whether we want it or we don't. This was an offer from me, from me, and I get it. Yeah, I could have told you I didn't know until probably eight o'clock last night what the offer was actually going to be. I just knew that it needed to be done in public and that is why we did it the way we did it and it only lasted 15 minutes.

Mr. WALZ. Well, my commitment to you, Chairman, is to do this together because I think what these folks know and the public knows, they don't care if it is the Senate's fault or our fault; it is our responsibility. They have seen this song and dance. We have got to get it done and I stand with you to get it done.

Mr. MICHAUD. Thank you.

And as the Chairman mentioned——

Mr. WALZ. Who has yielded to you?

Mr. MICHAUD. No one.

Ms. Brownley has.

The CHAIRMAN. You are out of time. (Laughter)

Mr. MICHAUD. You know, I did lean over to the chair earlier and asked him what his proposal was. I am an optimist. The bottom line is now we know what the chairman's proposal is. We also know what the chairman's proposal is on the Senate side, which we have never seen in black and white either, so I think now we know where you both are coming from and hopefully we will be able to work in a bipartisan manner to get this thing done.

And I am not interested in blaming anyone. My concern has always been how do we take care of the veterans that we have to

take care of and I hope that both sides, that everyone on the conference committee will focus on that particular issue, as well.

With that, Mr. Chairman, I just say we probably ought to give Ms. Brownley her five minutes back.

The CHAIRMAN. Without objection. Thank you.

Ms. BROWNLEY. Thank you, Mr. Chair.

Just to chime in on this conversation, I agree that we—this must not—should not be—must be a bipartisan approach to this and we must collectively solve this problem.

And I will say that when the House passed the bill almost unanimously and when the Senate passed the bill almost unanimously, I think the expectation is we would go to conference and resolve the smaller differences and move forward, and I just don't want to take a large step backwards. But I think we are making progress. There is movement here, so we are making progress. We have got to continue to work to make sure that we do, indeed, have the resources to make sure that we can serve our veterans well once and for all.

And we all know that this has been a problem that has not—this crisis has been specific in terms of wait times, but we know that we have had issues with capacity and our ability to serve our veterans in the proper way for a very, very long time and this is our opportunity, I believe very, very strongly, for us to move forward, and to once and for all, to be able to really try to make a difference in how we serve our veterans throughout our country.

I wanted to ask specific question. I think Mr. Weidman, I think it was in your testimony where you talk about the fact that you believe that the current leadership and the change in culture and the change in leadership is beginning to permeate at the upper levels, but it is not necessarily permeating throughout the VISNs and the VA hospitals across the country so forth and so on. And I think, obviously, that has to happen—for culture to change, that has to happen. I am wondering if there is anything that you believe we should be doing to assist the VA to making sure that that communication does get to the VISN level, to the hospital level, to the CBOC level, at every corner throughout our country where we are serving our veterans. Is there anything that you think that we should be doing?

Mr. WEIDMAN. I suggest that you get your district staff together with your veterans advisory committee and I know that most of you have them, and give them a copy of Acting Secretary Gibson's memo that you will meet with the VSOs every month and you will jointly put together the agenda for those meetings. Because we are getting back—I know the memo got out there, but people aren't responding and our folks ain't hearing much, and it is—the—best persons you have at the VA are the veterans in your district, ma'am. And if you give them the right information, they will pick up the ball and start to run with it, and if it is real wrong, they will go to the press.

Ms. BROWNLEY. Thank you for that.

And, Mr. Blake, you are the budget guy, the annoyed budget guy here, and the VSOs, I mean you have done—you must have done a needs assessment of what the VA needs and what it costs. I mean do you have that information?

Mr. BLAKE. I do. If you prefer, I have it. It is a lot of numbers and gobbledygook. I think Mr. Weidman said that. I would be glad to share it with your staff.

You know, we are fortunate that we—every year we meet with John Towers and Nancy Dolan and the staff of the committees and we put out the same invitation to the legislative assistants for all of the offices to discuss this very issue, to discuss what we recommend.

Ms. BROWNLEY. Well, can you, based on your needs assessment, can you give me a ballpark figure of what you think the needs are budgetarily, to meet those needs?

Mr. BLAKE. For this year or overall? I can't project them in the way that the VA just said they need \$17 billion out through 2017.

What I can tell you is the IB recommendation is approximately for all medical care about \$2 billion more than what the VA recommended for fiscal year 2015, which will be starting soon and something less than a billion dollars or approximately—don't quote me on that—approximately a billion dollars more for fiscal year 2016 as an advance.

What I will also say is over the last ten years, the difference between what the IB has recommended overall for medical care is \$8 billion more than what has been appropriated, and I can tell you that for the most part, what has been appropriated is virtually equal to what has been asked for by the Administration. There has not been a whole lot of difference between those two.

So basically over that period of time, what I would suggest to you is if that kind of commitment had been made over that period of time, maybe it would have incrementally built capacity in. I think part of what is hard to stomach about \$17 billion right now is—and this gets to the chairman's concerns about spending resources appropriately and all that—can they really spend \$17 billion in such a short period of time appropriately to get the right staff in the right place doing the right thing, and that is the concern.

Whereas, if it had been done incrementally over a greater period of time, in a perfect world it would have been done correctly, at least.

Ms. BROWNLEY. I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Cook.

Mr. COOK. Thank you, Mr. Chairman.

Appreciate everyone here. I try to keep up with many of the organizations. The four of you, I pay my dues and I get my magazine. I always make my joke about the calendars, but I won't. I am going to ask you the same question that I have asked other veterans organizations and I will probably ask it if I am still around in six months or what have you.

You know in a military environment whether a unit is combat ready or not combat ready. It is very, very simple. As of today, is the VA combat or mission ready or not mission ready? Mr. Nicholson, do you want to start?

Mr. NICHOLSON. I'd say it is not fully mission ready, absolutely not.

Mr. COOK. Sir.

Mr. WEIDMAN. At least half of the hospitals aren't mission ready.

Mr. VIOLANTE. I would say they are not mission ready, but they are moving in that direction.

Mr. BLAKE. When I was in the army we had X and circle X for maintenance concerns and I would say that a lot of places are circled X.

Mr. GALLUCCI. I would agree, not mission ready, and I think that the veterans who have contacted us share that concern.

Ms. JONES. Not mission ready, and we have seen evidence of that throughout the crisis across the country, not mission ready.

Mr. COOK. Thank you.

Your organizations, you have a lot of credibility. You have a lot of credibility throughout the United States with this panel. Do you rate different hospitals by region, one, two, three, four, five, and do you give a reason why one is, you know, great care, fully staffed, what have you?

And before you answer, the reason is coming from a military environment, whether you like it or not, you are always rated—fitness reports—everyone here, we get—somebody scores us on this bill. It is just a way of life, but it almost is, you know, you call attention to that.

Back when I got out of the Marine Corps and became a professor and they had this—I tell everybody, rateyourprofessor.com and it was like, oh, boy, who is disgruntled this week or who loves me this week? I probably gave everybody eights, but—no, I won't go into that.

But do you think or do you right now rate hospitals? Do you rate other aspects of VA and publish them in your magazine, sir?

Mr. NICHOLSON. IAVA does not. We don't have the capacity. We are a smaller—we might be—but we are a small organization and don't have the staff and resources the others do.

Mr. COOK. Okay.

Mr. WEIDMAN. We do not, sir.

Mr. COOK. Okay.

Mr. VIOLANTE. DAV does not.

Mr. BLAKE. We don't rate, but we certainly evaluate the SCI centers specifically, and while we don't publish a list, I am sure I can put that question to senior executives that oversee that and they can list every SCI center in the VA system in rank order from best to worst.

Mr. GALLUCCI. We do not rank hospital systems.

Ms. JONES. The American Legion doesn't necessarily rank the systems, but our system saving team and task force go out to different facilities across the country and we provide—do site visits. We look at each individual hospital to see what is going on and we hold a town hall meeting, as well, to talk to the veterans in that local community to understand their concerns as well and then we meet with leadership.

Mr. COOK. Okay. The reason I brought that up is obviously in the previous panel and I had to meet with some folks' trust and confidence, and you know, I was very honest, I have problems with trust and confidence in the VA. I got a lot of trust and confidence in you guys, and maybe because we go back a long ways and what have you, and you have helped me. So I am not trying to get you

involved in a situation like this, but you do have credibility and you got—at least with me, and so it is something to consider.

Now, Mr. Weidman, I want to ask you about Vietnam veterans. You know one of the issues I have, and maybe because I am a Vietnam veteran, I always felt that, you know, after the paralyzed veterans, people that needed care right then and there, that I always felt like the VA was, ah, Vietnam veterans—and this is something that the Vietnam veterans told me—that, ah, you guys are at that stage, you are probably going to be dead before you get seen for an appointment let alone treated.

And I am wondering and I actually do think because of the age factor and they probably have more debilitating illnesses and what have you, and—but I am very, very concerned whether that is a perception with your organization that—and this is based on the history of what happened years ago where the country turned its back because, oh, you served in Vietnam, you are a baby killer, et cetera, et cetera, et cetera.

So I am specifying exactly if you could address that issue.

Mr. WEIDMAN. Well let me just say that because of that our founding principal is really very straightforward and very simple. Never again will one generation of American veterans abandon another, and we don't, and so we have put a lot of resources, even though where by choice, a bunch of old guys and gals—

Mr. COOK. Easy now, I am one of those.

Mr. WEIDMAN [continuing]. But we do a lot of things for the younger vets and we do things for our fathers' generation, even though they basically told us to go pound salt.

Now having said that much of the care at the VA is—most of it is good, some of it is very good, and sometimes excellent. The problem in the perception that we are getting back from our members is, particularly when it comes to PTSD and neuropsychiatric wounds, that they are being pushed out.

And, you know, on a triage I was a medic with the 196 Americal, and the hardest thing I have ever done in my life is have to triage for real under fast changing circumstances. And maybe they are triaging, but that is—the way in which we regard that is, if you don't have the resources you need in order to do all the job ask for it, and if they don't give it to you, and this begins at the clinic level, then hospital, then VISNs, then national, and they don't give it to you shame on them, but if you don't ask shame on you.

Mr. COOK. Thank you.

I yield back, and thank you for what you do here. Appreciate it. The CHAIRMAN. Thank you, Colonel.

Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman.

I think we all agree there are serious problems at the VA, but I was very glad to hear you answer Mr. Takano's question, mend it not end it, and I appreciate the chairman saying that we are not out to do away with the VA, but I especially appreciated a very articulate statement that you made, Mr. Blake, okay, expressing some concerns that I share with you about this push to privatize.

Now, I can't help but believe that this is part of an agenda, by some, not by all, but just to kind of dismantle the federal govern-

ment and leave citizens, in this case veterans, out there to fend on their own in the so-called private sector.

Now if you look at what is happening here with the private care and the push to private care maybe this is a short-term fix as one of you mentioned, but specifically some of the concerns I have about that are things that we need to address before we go pell-mell down this direction.

One of them is just as you raise, there are concerns that doctors and hospitals as they admitted themselves don't have the culture of the VA, they don't have the expertise of the VA, they aren't used to dealing with the kind of problems that veterans have, whether it is PTSD or Agent Orange. So if we push them out there into the private sector we don't know that the quality of care is going to be any better.

Second, this committee asked over and over, give me the hard facts, give me the numbers, give me this, and yet there is no evidence out there to show that if you put patients in the private practice that it will be cheaper, faster, or better. In fact we just don't have that information. In fact if you looked at kind of a roughly parallel situation like Medicare Advantage you would find that the evidence is actually to the contrary.

The third thing, and Mr. Takano mentioned this too, is the lack of doctors in many parts of the country. I am in Las Vegas, there is rural Nevada, we just don't have physicians, we are at the bottom of every list for different specialties, and also just general practitioners, and so if we send them out to the private sector that doesn't mean they are going to get it faster or even they are going to be able to find the care. Yet if we pass this conference bill that is going to be the national news, veterans sent to private care, veterans can now use private care. Well that is just not going to be true.

And I wonder, how are you going to tell your members what to do now under this new scenario? Anybody?

Mr. GALLUCCI. Well, I think first and foremost one of the important things to look at in the access and accountability bill is that we have far too many veterans waiting far too long for care.

I am a strong defender of the VA system. To be perfectly honest I probably wouldn't be in this position if it weren't for the help that I received from the VA system when I returned from Iraq. That being said as a patient in the VA system I have also had appointments cancelled on me. I have had—I have shown up to clinics where they have said, well, we can't see you today. I have had months long waiting periods for appointments. And I am just one example.

I guess the problem is we need to balance it correctly. Outside care can be appropriate at times, but we can't use it as a catch-all, as I outlined in my testimony, or a supplement for the competencies that the VA has, especially on issues like combat-related mental health care, prosthetics, or any other specialty services as my colleague, Rick Weidman, said related to toxic exposures in the war zone.

Mr. VIOLANTE. You know, and you are exactly right about private care. I have a secretary in my office who went into a doctor almost four weeks ago now, she needs surgery, the doctor recommended

she have two appointments that she needed to make before she can have the surgery. One was scheduled at that time for this past Tuesday, the other one for in August. And so she needs to have both of those appointments met before she can go in for her surgery. So she is waiting over probably eight weeks in order to do that. So private sector isn't much better.

You know, it is frustrating because we have the acting secretary putting forth a plan that would insure that we had the capacity at VA and build up, you know, the number of doctors that need to be there, plus take care of veterans on the outside when necessary for an amount that is a fraction of what CBO has a cost estimate on for the bills pending in conference. I mean they claim 30 billion for the first two years and another additional 54 billion after that. And I mean that is what I don't understand is why we are, you know, condemning VA and their numbers when CBO is saying it is even going to be more than that. It is just frustrating.

Ms. TITUS. Mr. Miller.

Mr. BLAKE. Ms. Titus, I would say this. You know, from the perspective of a PVA member it doesn't matter what bill you pass, because at the end of the day the only and best option for our members is the VA. There really isn't another option out there. Yes, there are places out there that can meet some need they have, but there is no real option.

It is almost unfair to answer that question a little bit, but what I would say is, we have never said they shouldn't be contracting out for any—or purchasing care at all, in fact I think we have many times that the VA had done a terrible job of using that authority in the past. They are now seemingly moving more in a judicious manner to do that under their accelerated access to care initiative, you know, they have got NVCC now, they have PCCC, all these different things, so there is certainly an avenue to go there.

One of the concerns, and you mentioned this about the doctors that are out there in the private sector, one of the hearings—one of the oversight hearings, I am not sure if it was one of the midnight hearings or one of the daytime hearings this committee had, but Mr. Ruiz made a point at one of the hearings that when they did an analysis of his district, granted his district is pretty rural, but it is not unlike a lot of districts in this country, when they did an analysis of his district they discovered that there was approximately 1 physician for every 9,000 people in that district.

Ms. TITUS. Uh-huh.

Mr. BLAKE. I would suggest that is probably an underserved district by in large, and there is probably a lot of other places in this country. There are a lot of underserved veterans in many of those same areas, so what happens when you put them into that situation?

Ms. TITUS. Exactly.

Mr. BLAKE. So there is certainly a concern there.

Ms. TITUS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. And also it is 17.6 billion over and above the CBO score, so the fact that it is a lower number I understand that, but it is 35 billion plus 17.6.

Mr. WALZ.

Mr. WALZ. Thank you, Mr. Chairman.

And I think and that is a valid point. I think all of us where you get it, we are trying to separate adequate resources from effective use of those resources and we are calling for both, and if we conflate the two together we end up going in the wrong direction.

But I would like to point out though, and I don't know if this has happened since I have been here, it may have, but it is certainly for me gratifying. Oftentimes we see people up here testifying and you guys standing behind them, both figuratively and literally standing behind them as veterans, the acting secretary stayed throughout this whole thing, and I don't know if any of us have seen that before, but I want to make note that actions speak loudly to all of us. As we know words are cheap, especially sometimes around here.

This is a pivotal moment that we are at, pivotal. The decisions that are going to be made as I said over the next weeks and months are going to I think could have decades long impact. I think you are absolutely right to flex your—the ability of pressure points to get situations done, but keep in mind, and they are right to have those when you can turn up the heat or whatever, but now there is going to be a race to get something done by next Friday. And getting it done and getting it right are not necessarily synonymous.

And so my concern is as we work together and as we bear down on this, because there is no question that we all want to get it right, the spats you are seeing here are actually fairly healthy in this committee, they are aired openly, they are there. I need all of you to think deeply, and as you are doing is how do we get to that point? Because here is my biggest fear. We pass something, everybody goes home in August and pounds their chest, there is more money in the system or something, and now the VA is taken care of.

I would go back to what Mr. Nicholson said, we have got to multitask here. His point on suicides is, the chairman and I just introduced the Clay Hunt Safe Act, which I would say is critically important going forward, and if now, oh, the VA work is done and we will move on to the next crisis of the day or whatever it would be and forget that.

We need to make sure that we are looking at the long game. We need to make sure we are looking at that national veteran strategy, and we need to figure out a way—and you guys have said this too—Alex, when you said you weren't consulted on who the next secretary was going to be, don't feel left out, I was not either, so—and that—and I bring to that not necessarily facetiously, I bring it to the point is you said it and I think Carl it might it have been you who said it, we are all responsible for this, and you took responsibility as an organization and I take responsibility.

The question I have is, I am okay taking responsibility until I have no teeth to effect what is being done. And I would suggest to you and try and figure this out, this committee is your entry point into this system in many cases. You are right, MILCON VA Appropriations, heck, I don't even know who is on it. I mean that is what happens on that. Good luck getting in over there or having Armed Services come over here.

So I am making the suggestion, been making the suggestion, I will take responsibility, but why does the second largest agency in the federal government have one of the smallest committees? How come we don't have the resources to do more on that? How come we don't have the ability to get out there? And how come we are not adding you in as partners with the VA?

So I think as you look at this major reform, as you look at what the long-term implication is, don't forget that if the peoples' influence is going to be felt it is going to be felt through this committee, and we have to have the resources, we have to have the ability, and we have to have your backing as partners to getting this done.

So with that being said I am just going to leave it all to you. What do all of you hope to see come out of the conference, and it will get done. Chairman Miller's leadership, Mr. Michaud's leadership, they will work with Senator Sanders, we will get this thing done, but has to, what is the redline that has to come out of that? What has to be done before we go home? Because as Mr. Gallucci as your organization said, don't worry about coming back if you don't do it. If we are going to come back what do we have to get done next week?

Mr. GALLUCCI. Well thank you, Mr. Walz for the question. Yes, what we put out was very strongly worded and our members are very frustrated by what we have seen. And we certainly echo the frustrations of Chairman Miller and the rest of the committee in how we get to a quality product.

I think from the membership—from the perspective of the VFW what we want to see come out of this is an adequately funded—or adequately resourced—I don't want to say funding, that is—adequately resourced VA health care system capable of delivering health care in a timely manner to veterans, and when it is incapable of delivering that timely care to veterans that they have the resource and protocols in place to delivery it through either contract care or just through non-VA care coordination.

And in addition to that the accountability side would be that VA has the ability to properly sanction and fire poor performing employees and replace them in a timely manner.

There has been a lot of talk about that front end, about how many people have you fired, how many people have you fired? Well, I outlined it in my testimony and I have been talking about this for the last two months, I think VA makes tradeoffs many times in the way that they evaluate their employees. If you can't hire a quality replacement in a timely manner why—are you really going to give a poor performance review to somebody or try to fire somebody when you can't replace them or when there is the threat of them leaving? If you have a clinician seeing two patients when they should be seeing five are you going to fire them when you know it takes another year to replace them? And then those two patients go without care.

Mr. WALZ. My time is up. Maybe if we come back around on a second round I will get the answers to this to each of you, because it is important for us. I have got to know what—at the end of the day we are going to vote yes or no, and we have got to know what we are going to do.

The CHAIRMAN. Mr. O'Rourke, five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

I first want to thank each of you for being here and I want to thank you and your organizations for helping me as a new member get up to speed and better represent the veterans that I serve in El Paso. Your feedback on bills that we will be voting on, on bills that we are offering has been instrumental, they have improved the legislation that we have been working on, I have been making better decisions for your feedback. So I want to thank you.

And I especially want to thank Ms. Jones and the American Legion. As we were discovering how awful the crisis in El Paso was about the gap in coverage, about the wait time for disability claims, and then the wait time on appeals for disability claims, and we are hoping to get some kind of response from the VA, which since then has come. You and your organization stepped in to fill the gap, literally set up a command center and saw hundreds and thousands of veterans there, connected them with benefits, connected them with care, and I cannot thank you enough for doing that. So really appreciate what you are doing.

Let me follow up on one of the achievements that the secretary cited and that I am very grateful for, which is removing that 14-day deadline and moving it back to 30, accelerating access to care, putting money into the local VAs to make sure that we could access that. And by that same model and thinking about El Paso where I mentioned earlier if you were here that we had nearly 20 full-time vacancies in mental health, we have 20 full-time vacancies today. We had a commitment from our VA director and Dr. Jesse and Dr. Petzel before him that we would have those filled by the end of this month. We just checked in this morning, they will not be filled.

PTSD, mental health care, being able to help somebody who is in need and who may be a danger to him or herself or to a spouse or loved one or the community and at best may just be suffering without help is a critical unmet need within the VA, certainly in El Paso, but I understand throughout the country.

Guide me through this idea proposed by a panel week before last that the VA focuses and prioritizes and becomes excellent in care for PTSD, TBI, prosthetics, the kinds of combat and war-related injuries that we are seeing from all of our engagements, especially post 9/11, and refer other care that is not combat or war-related out into the community. In other words give me the ability to say to the veteran in El Paso, if you have PTSD you are going to come to the El Paso VA, you will be seen quickly, you will get the best care, you will have consistency in care, you will see a psychiatrist, you will have access to medication. I can say none of those things right now.

And part of my suspicion is that we are trying to do too much, and whether it is 17 billion or 30 billion we cannot spend enough to sustain a system that is today serving 9 million veterans it will be many more years from now.

Walk me through my thinking and how I could approach this idea and problem of balancing, creating excellence within the VA with accessing resources in the community. And I will start with Ms. Jones and work down the line for anyone who would like to respond.

Ms. JONES. You know, I think if we can answer that question and walk you through it we wouldn't absolutely have to be here today. That is an excellent question. There is so much that needs to be done. As a matter of fact the American Legion, we have a TBI, PTSD committee full time to research PTSD and TBI and what needs to be done next. There is so much the veterans needs, especially as evidenced while we have been out, you know, across the country talking to veterans who have been in crisis.

I think that there are times when veterans need to be—when purchased care is necessary, depending on the veterans, how far they live away, what their conditions are, whether it is advantageous to the veteran to be seen outside the VA that particular time. It may be harmful for them to drive in. All of those things taken into consideration.

I think what has to happen is the VA has to become experts in every area that veterans—where veterans need things. TBI, PTSD, women veterans' issues, all kinds of speciality clinics. Veterans have conditions that need to be taken care of and they need to be able to come to the VA and expect excellent care in all areas from the VA.

We cannot use purchased care as a substitute for what the VA needs to do. That is a cope out. The VA needs to be able to do excellently what they have been created to do.

Mr. O'ROURKE. Anyone else want to comment on essentially offering fewer services but doing them better and referring the remainder out into the community? I have about ten seconds left, so with the chairman's indulgence maybe we can go over a little bit, but—

Mr. BLAKE. I would say this, Mr. O'Rourke—

The CHAIRMAN. Five seconds.

Mr. BLAKE. Thank you, Mr. O'Rourke, I rest.

I would say this, you know, let us not forget that the VA is a fully integrated health care system and all of the components of it support one another, so if one of our members who has a spinal cord injury needs primary care he gets primary care in the VA and he needs that to be good care, and you can't just send that SCI veteran out. If they need audiology, which is kind of a basic service, which seemingly could be purchased in the community, that should be provided in the VA. If they need orthopedics, which is very common, the expertise should reside within the VA, because those things all prop one another up and that veteran depends on all of those things over the course of their life.

The concern becomes if we send them out for primary care, audiology or what have you, is that care really being coordinated, is the VA managing it, are we keeping track of what is going on so that all of the aspects of that veteran as he is being treated are being properly managed? And if you start sending out pieces you lose a lot of that I think, and then you ultimately put the overall and long-term health of a veteran, particularly veterans with the most complex needs, in jeopardy.

Mr. O'ROURKE. Great. Great feedback. Thank you. Thanks again. Mr. Chairman, thank you.

The CHAIRMAN. Mr. Walz, you had an additional question you wanted to ask?

Mr. WALZ. Just if anyone wanted to follow up on. We are going to make a decision next week, what do we have to come out with?

Mr. BLAKE. Mr. Walz, I would say this, you know, I had kind of resigned myself to something was going to pass, and truth is paralyzed veterans of America in particular has some concerns with the Choice Act and those provisions.

The great irony of this is, both of the committees went into a conference with the most—probably the most difficult part of legislation virtually mirroring each other, the rest is some other provisions in the Senate bill, but the heavy lifting has been done because you went into a conference with bills that are very close to one another, and somehow you are going farther and farther apart on your own. I don't even know how that happens. It is just amazing.

So I kind of assumed that the Choice Act or whatever the final name is going to be was going to pass. My concern is not that bill because we just assumed it, my concern is what happens next? I don't want this to become the end of the debate, and Mr. Chairman, that is why I made the point, we need to—we don't want to thump our chest you said. If we go home in August and everybody is going to say look at the great things we have done for veterans and lead into the election and whatever and we forget that there are still serious problems that have to be addressed in the VA.

So it is not just about what comes out of legislation, because I just assume you are going to pass legislation pretty much like it looks. It is going to be what are we going to do after the fact?

Mr. WEIDMAN. As long as something gets done. And I think that we are under tremendous pressure just like all of you are under tremendous pressure to enact something, and to start to really truly address it, but really truly addressing the crisis is in terms of it not being repeated anytime soon is going to be several years of effort. Not just of funding, but of effort, to rebuild a management structure that you can have faith in. And every time I talk to VA employees they say, well what do you think about it? I said, I think this is before all this blew up, that we need VA management as good as most of the clinicians and workers within VA and we don't have it, and we haven't had it for a long time. Didn't begin with this administration. And so that really needs to get really the primary focus.

One last thing, and Ms. Brownley has left, there is no fixing it once and for all. It is not a widget. It is an institution of people that will change as the needs of the people change and as the Nation itself changes. And so we regard it much more as a garden that you need to continue to plant and fertilize and weed, and the weeding hasn't been done in management in a long time and that is what needs to be done now.

Mr. VIOLANTE. Mr. Walz, my concern is again as my colleagues have said, this is a temporary fix. I think we are heightening the expectations of veterans and not going to be able to meet those expectations, and I think in the end I think we could even be weakening VA instead of making it strong, and we need to make sure that in the end VA is stronger and that they are able to fulfill their mission to the veterans.

Mr. NICHOLSON. And can I say just briefly that my biggest concern with the conference right now is the House and the Senate passed several really good bills, and you went into the conference with our understanding being that the jurisdiction of it was going to merge those two bills, to make some tweaks, and pass it out. Now everything—it seems like everybody and their brother is wanting to throw in extra things because they see this as one of the only if not the only moving trains on vets issues perhaps before the end of the Congress.

Now if you all could focus on, and you certainly have our support in doing so, merging and tweaking and finalizing what you passed and getting that done and not throwing in all these other provisions that people, you know, want to put on the moving train, the 17 billion extra. I mean I think if you guys could pass what you have in front of you now within the jurisdiction of the conference committee and then—in my opinion—and then tackle the supplemental that we would come out with something for sure, whereas, if we are adding in everything else and considering everything else and then having to fight over and discuss whether or not to pay for it and how to pay for it, et cetera, we may end up with nothing. And if we go into August and this doesn't get done and a new secretary is confirmed and then he comes in and he wants to make adjustments to the 17 billion or maybe add another 17 billion who knows what we are not going to get anything done.

So I would rather see you all finish what you started with, get that done, and then move on to step two and three.

Mr. WALZ. Well, I appreciate that, and I think that has been my position that we triage this, we deal with the access to crisis care, we work with you as you are getting there, we start to deal with some of those, and then we breath a little bit, we have a long-range vision, we put that in place, and we continue to follow through. Because I too have as you have all expressed have this great fear, and you know how this is going to go, it is going to be well you are already done with this, this is your one bite off the apple, it is done, don't come back asking for anything, don't do this.

And, Rick, I always say with the VA and health care it is a journey, not a destination, we need to keep moving forward. But there is a danger because I hear from people if we don't do this and we don't do it now the window will close and wouldn't get done. I think they are missing the passion of the American people to get this right and sticking with us. This is our time.

So a little bit of patience, an awful lot of collaboration continuing this on, and the help from you would be is, help us keep the realistic expectations on that, don't have the all or nothing by next Friday but have danged sure better do something you better do and you better get some results out of, and then keep the momentum to keep moving forward.

I yield back.

The CHAIRMAN. Thank you, Mr. Walz.

I appreciate the panel for being here today and precisely what occurred last week when the \$17.6 billion was injected into this conversation is when things started going sideways. We were very, very close to resolving our differences, and Senator Sanders feels that the only time that he will ever be able to get this money done

is in this bill, and I have assured him that that is not the case, that if VA can make the case for the dollars in certain areas that they are asking for that we will go to work to see that they get those dollars. Unfortunately he has convinced other people that this is the only way to get this \$17.6 billion put into this emergency bill. That is not the case.

The House had actually narrowed the scope down in our bill to access and to accountability. Ours was more narrowly crafted than what the Senate had, but we were giving and taking, adding things in, taking things out, the House was receding to positions that the Senate had.

So again, as I understand Senator Sanders has just held a press conference, I can't believe he unilaterally held a press conference without letting me know he was holding a press conference or asking for my permission, but he did, and I think that the thing is we are not done. We did not give a take it or leave it offer. We just want to make sure that those that are on the conference committee understand that the House is not trying to say everything has to be paid for. We are going for the same number. The House has actually gone to the Senate number. We did that when the CBO came out with the second score instead of holding to our number, which was higher because we had a 14-day trigger, we went to the 30-day trigger.

And so understand, just as Mr. Walz has already said, getting this done right is important. It is critical. And that is what we are committed to doing, and I have assured everybody on the conference committee that if it takes staying through the weekend this weekend I am prepared to do that. I was supposed to be at Normandy for the 70th anniversary as the chairman of the committee that has oversight over the American battle monuments, and I did not go because I stayed here to help negotiate this bill. I stayed in Washington an entire week. And so I am committed as are all the members of this House committee to making sure that we get it right, and with your help we will, and we will get it done in a timely fashion that serves the veterans.

Remember, the veteran is the most important thing, not VA.

And with that we are adjourned.

[Whereupon, at 2:03 p.m., the committee was adjourned.]

APPENDIX

Prepared Statement of Jeff Miller, Chairman

Good morning.

I would like to welcome everyone to this morning's oversight hearing entitled, "Restoring Trust: The View of the Acting Secretary and the Veterans Community"

Today, the Committee will examine what steps we need to take to help the Department of Veterans Affairs back on track to meeting its core mission—to provide quality health care to our veterans. Since the beginning of June we have held almost a dozen Full Committee oversight hearings, some going into the early hours of the morning, to do a top to bottom review of VA and to delve into how we arrived at the current crisis.

It is time for this Committee, the Department, Veteran Service Organizations, and other stakeholders to come together to get it right for those who selflessly served this country. While I hope to focus on the major themes we've covered and receive updates from VA on the topics we have covered in the last few weeks, I can promise the Department and Committee Members that as we move forward to mend VA's broken system, the oversight done by this Committee will continue.

Mr. Secretary, in your written statement, you state that "the status quo in our working relationship must change," and that "the Department will continue to work openly with Congress and provide information in a timely manner." First, I agree that the relationship between VA and this Committee must change. We must go back to the way business used to be handled for decades when Members and staff could communicate directly with VA senior leaders about the routine business we conduct with VA. But using the phrase "continue to work openly" is, in my opinion, not a reflection of the current reality we are in. Members of this Committee, other Members of Congress, and our staffs are still being stonewalled to this day.

For example, the day after our July 14th VBA hearing, our colleague, Mr. Jolly personally spoke to Kerrie Witty, the Director of the St. Petersburg Regional Office, and asked for information regarding the firing of Mr. Javier Soto, a whistleblower who testified at that hearing. Mr. Soto had raised very serious concerns on both retaliatory action and mismanagement at the St. Petersburg Regional Office, and it is incumbent upon this Committee to investigate those allegations.

Instead of being open and honest about the process about Mr. Soto's removal, VA has equivocated, stonewalled, changed its story, and obstructed Members of this Committee in what appears to be an attempt to cover up VA's retaliation against Mr. Soto. And this is not the first time this Committee has received a back and forth response from VA. I am prepared to subpoena the relevant documents related to the Soto firing as well as employees of the St. Pete RO and Central Office if we do not get a prompt compliance with our multiple requests.

Secretary Gibson, I could not agree with you more that the Department needs to earn back the trust of veterans, their families, Members of this Congress, VSOs, and the American people through deliberate, and decisive, and truthful action. The recent scandals that have tarnished our trust in the VA, are a reflection of a broken system that didn't just develop overnight, nor can it just be fixed overnight. The Department cannot continue to reward failure, or turn a blind eye to illegal and unethical practices, or ignore incriminating IG and GAO reports. Upon stepping up as Acting Secretary, you have stated that there must be change and accountability, but I still have yet to see where the Department has drawn the line and brought bad actors to justice.

We have shown through many of our hearings that one contributing factor to the current crisis is that VA has clearly lost sight of its mission and that extra funding didn't go to improvements in patient care but toward ancillary pet projects and an ever growing bureaucracy. According, to an article by former Under Secretary of Health, Dr. Ken Kizer, in the New England Journal of Medicine, "VHA's central-office staff has grown from about 800 in the late 1990s to nearly 11,000 in 2012" further illustrating VA's shift of focus to building bureaucracy as opposed to fulfilling its duty of providing quality patient care. VA needs to return to what it was intended to be, a patient-centered-care agency for our veterans.

As I said before, the problems at VA cannot be fixed overnight, and it cannot be fixed by simply throwing more money at those problems. To date, VA has been given every resource requested by the Administration. Every year during our budget oversight hearings we have asked the Secretary if he had enough to do the job, and every time we were told unequivocally "yes".

This is why when Acting Secretary Gibson said last week that an additional \$17.6 billion was needed to ensure that VA is able to deliver high quality and timely health care to veterans, it came as a shock to many and raised obvious questions.

Where exactly did this number come from? What assumptions underlie this request and are they valid? What effort was made to look within existing resources to meet this new resource need? I know many of my colleagues would agree that after multiple oversight hearings done by this Committee, our internal investigations, outside investigations, and countless accounts made by whistleblowers—VA's numbers cannot be trusted. VA's determination that 10,000 additional medical staff is needed is also surprising when in the Secretary's written statement it states that VA doesn't "have the refined capacity to accurately quantify its staffing requirements." If they don't have the ability to accurately predict staffing needs then how do we know that 10,000 more bodies is what is needed? Again, VA's numbers are something I believe many of us call into question, and I believe a better understanding of where these numbers were pulled from is needed.

I would also remind members that we also don't have any type of a grasp on how the Department is going to spend the new funding they have requested. The President's FY 2015 budget request for the department is over 1300 pages long. [SHOW BUDGET BOOKS HERE] The request we received from VA is five pages ... just five. Clearly not the type of justification anyone would expect for \$17.6 billion dollars.

Our veterans certainly deserve the best, but just throwing billions upon billions of dollars into a system that has never been denied a dime will not automatically fix the perverse culture that has encompassed the Department. Real change needs to be made in the management at the Department to refocus on the core mission and in the priorities of the VA. VA can no longer consider itself a sacred cow that is not subject to the rules of good government and ethical behavior. Veterans are sacred. VA is not.

Ultimately, we are talking about a system that has a long road ahead of it before it can get back to an organization deserving of our veterans and the sacrifices they've made. I hope that today we receive the needed insight from our Veteran Service Organizations. They and their members are on the ground and need to be partners as VA tries to rebuild the trust it has lost. I hope that together we can bring about true change to this broken system, and change the corrosive culture that has encompassed the Department of Veterans Affairs for far too long.

With that, I recognize the Ranking Member, Mr. Michaud, for his opening remarks.

PREPARED STATEMENT OF MIKE MICHAUD, RANKING MEMBER

Good Morning, and thank you Mr. Chairman for holding today's hearing—and for leading our rigorous oversight these past few months.

It's been a long road getting here. The hearings we have held over the past few months have yielded difficult, disturbing, but ultimately—important—information.

With each hearing, we heard of a different aspect of the Department of Veterans Affairs that just isn't working. We heard about some challenges—like the claims backlog and technology issues—which we have been confronting for quite some time now. We learned of others—like how the VA treats whistleblowers, and the reliability of the data VA reports—that were new.

The VA has a good product. When veterans get in to see a VA doctor, they like the care they get. When veterans get an eligibility rating and start receiving VA benefits, they find those benefits useful and helpful.

But, the business model for producing, delivering and supporting the VA product is fundamentally broken. We have heard this time and again over the course of these hearings. There is a clear cultural problem at the VA. There are scheduling failures and technology problems. Inconsistent office practices lead to backlogs that appear to be tackled at the expense of other services.

VA is a sprawling agency that offers critical services to millions of veterans. It's clear to me that we need a business-minded approach to reform the agency. More of the same isn't going to solve the underlying problems. Tweaks and band-aids around the margins aren't going to sustain the system. We need a new model, a new approach, a new way of thinking about and looking at the Department. We need immediate, short-term fixes. But we also need a long-term vision and a new approach to the business of VA.

I'd like to thank Acting Secretary Sloan Gibson for joining us today, and for his efforts over the last few months. Mr. Gibson, you stepped up to the plate at the most challenging moment in the VA's history, and you owned the problems the organization was experiencing. I thank you for your increased efforts to communicate

with us here on the Hill, for your dedication to our nation's veterans, and for exhibiting the courage to be the face of the VA during this difficult time.

I'd like to similarly thank Bob McDonald, who I hope will soon be confirmed as the next VA Secretary. I'm meeting with Mr. McDonald tomorrow and I'm looking forward to discussing with him his vision for reforming the VA, both in the short-term and the long-term. Like Mr. Gibson, Mr. McDonald is exhibiting extraordinary courage and commitment for taking on this role at this moment in time.

I'd also like to thank our Veterans Service Organizations for joining us today. You have been strong and relentless advocates for the well-being of veterans. You have done an excellent job holding all of us—in Congress and at the VA—accountable. You are key stakeholders. You need to be actively engaged in the process of long-term reform at VA. Thank you for joining us today, and I look forward to continuing to work with all of you.

And with that, I thank you Mr. Chairman and yield back my time.

PREPARED STATEMENT OF HON. CORRINE BROWN

Thank you, Mr. Chairman and Ranking Member, for inviting the Acting Secretary here today.

Mr. Secretary, it seems so long ago since you first testified in front of this Committee. It was only 3 and a half months.

At the time you were the Deputy Secretary and I feel that you have acquitted yourself very well in your time at the VA.

I do hope you will stay on at the VA and help guide the Department through the rough times to come.

The VA operates 1,700 sites of care, and conducts approximately 85 million appointments each year, which comes to 236,000 health care appointments each day.

The latest American Customer Satisfaction Index, an independent customer service survey, ranks VA customer satisfaction among Veteran patients among the best in the nation and equal to or better than ratings for private sector hospitals.

I am confident in the health care our veterans in Florida are receiving. With eight VA Medical Centers in Florida, Georgia and Puerto Rico and over 55 clinics serving over 1.6 million veterans, veterans are getting the best in the world.

Over 2,312 physicians and 5,310 nurses are serving the 546,874 veterans who made nearly 8 million visits to the facilities in our region. Of the total 25,133 VA employees, one-third are veterans.

In 2013, 37,221 women received health care services at VA hospitals and clinics in Florida, South Georgia and the Caribbean—more than any other VA health care network nationwide. This means that more than 75% of women Veterans enrolled for VA health care in VISN 8 were seen by providers in 2013.

I am especially pleased at the new Jacksonville Replacement Outpatient Clinic that was recently opened. The two-story, 133,500 square foot clinic provides state of the art technology and increased specialty services including diagnostics, improved laboratory facilities, expansion of women's services, minor ambulatory surgical procedures, expanded mental health tele-health services and additional audiology.

When opened, the Orlando VA Medical Center will include 134 inpatient beds, an outpatient clinic, parking garages, chapel and central energy plant. Currently, the 120-bed community living center and 60-bed domiciliary are open and accepting veterans.

While this committee and many others concerned with the well-being of our veterans have been quick to point out what they think are some of the most horrible crimes in the history of man that have supposedly occurred at your department.

However, once this House passes the Conference report updating the policies of the VA and hopefully addressing the wait times our veterans have had to deal with, the real work begins. Your agency will have to work twice as hard to address not only the health care of the veterans but the culture that permeated the department.

How do you fix that? That is something you will need to work out. This committee will stand ready to offer suggestions as to how to work better for our veterans.

It is important that you keep the channels of communication open between not only your office and this committee, but your office and the Medical Centers.

You have visited many Medical Centers during your short tenure as the head of the VA. I am pleased you came to Gainesville. I look forward to many more visits over the coming years.

The VA provides quality timely health care to our veterans. We have a duty to make sure that all those who have defended this country when called upon and receive the care they have earned through their service.

QUESTIONS:

Mr. Secretary:

How do you feel about putting VA into wings of private or community hospitals, where all involved can share resources?

In my time on this committee, the mission of the VA has expanded from just providing service connected care for the veteran to holistic care for the veteran and his or her family.

This is a good change, but it comes at a price. How do you propose to continue this mission knowing the issues the VA faces at this time?

PREPARED STATEMENT HON. SLOAN D. GIBSON

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the House Committee on Veterans' Affairs, thank you for the opportunity to discuss with you changes within the Department of Veterans Affairs (VA). We at VA are committed to consistently providing the high quality care and benefits our Veterans have earned and deserve in order to improve their health and well-being. We owe that to each and every Veteran that is under our care.

The Veterans Health Administration (VHA) operates the largest integrated health care delivery system in the United States. VHA has over 1,700 sites of care, including 150 medical centers, 820 community-based outpatient clinics, 300 Vet Centers, 135 community living centers, 104 domiciliary rehabilitation treatment programs, and 70 mobile Vet Centers. VHA conducts approximately 236,000 health care appointments every day and approximately 85 million appointments each year. Over 300,000 VHA leaders and health care employees—many who also are Veterans—strive to provide exceptional care to nearly 6.5 million Veterans and other beneficiaries annually. While there are things that VA does very well, there are also areas that need improvement.

Issues VA is Facing

We have serious problems. First and foremost, Veterans are waiting too long for care. Second, scheduling improprieties were widespread, including deliberate acts to falsify scheduling data. Third, an environment exists where many staff members are afraid to raise concerns or offer suggestions for fear of retaliation. Fourth, in an attempt to manage performance, a vast number of metrics have become the focal point for staff instead of focusing on the Veterans we are here to serve. Fifth, VA has failed to hold people accountable for wrongdoing and negligence. And last, we lack sufficient clinicians, direct patient support staff, space, information technology resources, and purchased care funding to meet the current demand for timely, high-quality healthcare.

Furthermore, we don't have the refined capacity to accurately quantify our staffing requirements but are actively working to assess these needs. As a consequence of all these failures, the trust that is the foundation of all we do—the trust of the Veterans we serve and the trust of the American people and their elected representatives—has eroded.

I apologize to our Veterans, their families and loved ones, Members of Congress, Veterans Service Organizations (VSO), and to the American people. We can and must solve these problems as we work to earn back the trust of Veterans.

We have to earn that trust back through deliberate and decisive action—and by creating an open and transparent approach for dealing with our stakeholders to better serve Veterans.

VA Key Priorities Going Forward

To begin restoring trust, we have focused on six key priorities:

1. Get Veterans off wait lists and into clinics;
2. Fix systemic scheduling problems;
3. Address cultural issues;
4. Hold people accountable where willful misconduct or management negligence are documented;
5. Establish regular and ongoing disclosures of information;
6. Quantify the resources needed to consistently deliver timely, high-quality health care.

Current VA Actions

VA has taken a number of actions already to address its key priorities related to scheduling and wait times:

- Between May 15 and July 15, 2014, we have made 571,163 referrals for Veterans to receive their care in the private sector. VA made roughly 463,567 referrals during this same time period in 2013. Therefore, in comparison to last year, we had a 107,596 referral increase over this same time period. On average, each referral to private sector care produces seven visits or appointments for care. So here, we would expect the 107,596 additional referrals to result in approximately 753,172 visits or appointments for care in the community over and above the level of a year ago during this same time period.
- VHA facilities are adding more clinic hours, aggressively recruiting to fill physician vacancies, deploying mobile medical units, and using temporary staffing resources, to provide care to more Veterans as quickly as possible in our healthcare facilities. VA is addressing VHA's antiquated medical appointment scheduling system with VSOs actively engaged in the process. We have developed a three-part plan to improve VHA's scheduling system:
 - First, VA has just awarded a contract to both fix and enhance the Veterans Health Information Systems and Technology Architecture (VistA) Scheduling Legacy Software. This work will proceed over the next 12 months, providing much needed support for schedulers.
 - Second, VA is actively working on scheduling "apps" that are expected to roll out over the next 6 to 12 months. For example, one will replace the blue-screen roll-and-scroll with a point and click user interface.
 - Finally, VA aims to acquire a comprehensive "commercial off-the-shelf" state-of-the-art scheduling system to markedly enhance capability. VA is making steady progress toward the comprehensive solution called Medical Appointment Scheduling System (MASS). On June 18, 2014, VA hosted pre-solicitation "Industry Day" meetings with technology vendors to discuss the Department's upcoming scheduling system acquisition. This Industry Day presented an important opportunity for VA to communicate directly with potential vendors on all aspects of the upcoming scheduling system acquisition.

In addition, VA conducted a live scheduling system architecture question and answer session to ensure potential solutions seamlessly interface with VA's VistA electronic health record. Written responses to VA's request for information are being evaluated now in advance of publication of VA's final Request for Proposal. After selection, VA anticipates working with one VA site in 2015 to create software interfaces with MASS and a repeatable implementation pattern before beginning a system-wide implementation in 2015. Briefings and discussions have also been held with VSO leaders to solicit their input.

- We are putting in place a comprehensive external audit of scheduling practices across the entire VHA system and working on using an outside private entity to do the audit. We will begin those audits early next fiscal year.
- I have directed every Medical Center Director to conduct in-person visits to all of their assigned facilities. In-person site inspections include observing daily scheduling processes and interacting with scheduling staff to ensure all scheduling practices are appropriate. VISN Directors will also conduct similar visits to at least one medical center within their area of responsibility every 30 days, completing visits to all medical centers in their network every 90 days. To date, over 1,100 of these visits have been conducted.
- We are building a more robust, continuous system for measuring patient satisfaction by establishing a new program to provide real-time, site-specific information on patient satisfaction, including satisfaction measurements of those Veterans attempting to access VA health care for the first time. VA has now begun using its longstanding Survey of Health Experiences of Patients (SHEP) program to provide facility-specific monthly updates about access as experienced by Veterans—including how easy or difficult it is to obtain routine appointments, urgent appointments, and same-day answers to their medical questions. We plan to expand our capabilities in the coming year to capture further Veteran experience data using telephone, social media, and on-line means. Our efforts will include close collaboration with VSOs, with whom we have already met to begin planning our efforts. We also will learn what other leading health care systems are doing to track patient access experiences.
- I have personally visited 13 VA Medical Centers in the last seven weeks to hear directly from the field on the actions being taken to get Veterans off wait lists and into clinics. Those visits to Phoenix, Arizona; San Antonio, Texas; Fay-

etteville, North Carolina; Gainesville, Florida; Baltimore, Maryland; Washington, DC; Columbia, South Carolina; Philadelphia, Pennsylvania; Augusta, Georgia; Jackson, Mississippi; Albuquerque, New Mexico; El Paso, Texas, and St. Louis, Missouri have been invaluable to me, both from the perspective of speaking to Veterans, local VSOs and VA employees, and seeing firsthand what the scope and nature of the issues we face are, as well as the perceptions of those who receive our care and those who deliver it to Veterans.

- The 14-day access measure has been removed from all individual employee performance plans to eliminate any motive for inappropriate scheduling practices or behaviors. In the course of completing this task, over 13,000 performance plans were amended.
- VA is posting regular data updates showing progress on its efforts to accelerate access to quality health care for Veterans who have been waiting for appointments. The first data release was on June 9, 2014. These access data updates will continue to be posted at the middle and end of each month at www.VA.gov to enhance transparency and provide the immediate information to Veterans and the public on improvements to Veterans' access to care. We know that we must not only restore the public's trust in VA, but more importantly, we also must restore the trust of our Veterans who depend on us for care.
- Where willful misconduct or management negligence is documented, appropriate personnel actions will be taken—this also applies to whistleblower retaliation. At VA, we depend on the service of VA employees and leaders who place the interests of Veterans above and beyond self-interest, and who live by VA's core values of Integrity, Commitment, Advocacy, Respect, and Excellence. Accountability, delivering results, and honesty are also key to serving our Veterans. Those who have not performed and have not delivered results honestly, will be held accountable.
- I have frozen VHA Central Office and VISN Office headquarters hiring—as a first step to ensure we are all working to support those delivering care directly to Veterans.
- VHA has dispatched teams to provide direct assistance to facilities requiring the most improvement, including a large multi-disciplinary team on the ground, right now, in Phoenix.
- All VHA senior executive performance awards for fiscal year (FY) 2014 have been suspended.
- VHA is expanding our use of private sector care to improve access to health care for Veterans who are experiencing or who may experience excessive wait times for Primary, Specialty, and Mental Health Care. VHA is now operationally monitoring the effectiveness of our sites' use of non-VA care to ensure Veterans are receiving their timely care by looking at (1) the time stamps for consultation, (2) the authorization of referral, (3) the appointment completion, (4) the return of clinical documentation, and (5) the referral closeout.
- I sent a message to all 341,000 VA employees, and have reiterated during every visit to VA facilities, that whistleblowers will be protected. As I have stated in the past, we depend on the service of VA employees and leaders who place the interests of Veterans above and beyond self-interest. We are committed to ensuring that our employees have a voice without fear of repercussion. We are deeply concerned and distressed about the allegations that employees, who sought to report deficiencies, were either ignored, or worse, intimidated into silence. We will not tolerate an environment where intimidation or suppression of reports occurs. We will not tolerate retaliation against whistleblowers.

VA Personnel Updates

In the area of leadership, we have taken immediate action in areas where we are allowed without the confirmation process, to bring in professionals to help us in the immediate future:

- First, I named Dr. Carolyn Clancy interim Under Secretary for Health (USH). She will spearhead our immediate efforts to accelerate Veterans' access to care and restore the trust of Veterans.
- Second, Dr. Jonathan Perlin, a former USH at VA, currently on leave of absence from his duties as Chief Medical Officer and President, Clinical Services for Hospital Corporation of America, has begun his short term assignment at VA as Senior Advisor to the Secretary. Dr. Perlin's expertise, judgment, and professional advice will help bridge the gap until VA has a confirmed USH.
- Third, Dr. Gerard Cox has agreed to serve as Interim Director of the Office of Medical Inspector (OMI); a Navy medical officer for more than 30 years, and a former Assistant Inspector General of the Navy for Medical Matters, Dr. Cox

will provide new leadership and a fresh perspective to help restructure OMI and ensure a strong internal audit function.

- And last, as we complete reviews, fact-finding, and other investigations, we are beginning to initiate personnel actions to hold those accountable who committed wrongdoing or were negligent in discharging their management responsibilities.

To support this critical work, Ms. Leigh Bradley has begun a four-month assignment as Special Counsel to the Secretary. Ms. Bradley is a former General Counsel at VA and, most recently, a senior member of the general counsel team at the Department of Defense with direct responsibility for the ethics portfolio.

Veterans Benefits Administration (VBA)

Thus far, I have focused largely on problems and corrective actions related to VA's delivery of health care. However, that is only one aspect of our sacred obligation to care for Veterans. I also take seriously our commitment to providing timely, accurate benefits, in the programs VBA administers and maintaining the integrity of our data systems and claims processes. We understand that recent investigations by the independent VA Office of the Inspector General (OIG), media coverage related to those investigations, and issues raised at Congressional hearings have called into question whether the compensation and pension data and systems within VBA can be trusted.

VBA has a comprehensive program of quality assurance at both the local and national levels and extensive data quality controls built into its processing systems. VBA data is held at the national level—not on local data systems—and it is updated and protected every night with controlled access. We also have a dedicated analytics team that constantly reviews the workload data, looking for anomalies within the system so management can respond quickly. However, based on the improprieties recently identified, we are taking action to add more checks and balances as we work to improve delivery of earned benefits. I have directed that an expert team be assembled to determine possible scenarios where an individual might find a way “around the system” and decide if further controls are needed. Under Secretary Hickey has directed a 100-percent facility and desk audit of mail and documentation at all 56 regional offices. The purpose of the review is to ensure records management compliance and proper control, storage, and maintenance of claim mail and other benefit-related documents. VBA is applying for ISO 9001 certification—considered the ultimate global benchmark for quality management. This will provide external validation and additional quality assurance of VBA's data. If an individual employee is found to have “worked around” the standard claims process, VA will immediately take necessary actions, including proactive referral to the OIG. In addition, VA will continue to provide publicly-available performance data on benefits through VBA's Monday Morning Workload Reports each week at www.vba.va.gov/reports.

Resource Requirements

I believe that the greatest risk to Veterans over the intermediate to long-term is that additional resources are provided only to support increased purchased care in the community and not to materially remedy the historic shortfall in internal VA capacity.

Such an outcome would leave VA even more poorly positioned to meet future demand.

We have been working closely with the Office of Management and Budget for several weeks to develop the request for funding. While the amounts under consideration are large, in the context of VA's size, scope, and existing budget, they represent a moderate percentage increase in annual expenditures. Furthermore, a substantial portion of the funds required are non-recurring investments in space and information technology that would not be reflected in long-term run rates.

Resources required to meet current demand covering the remainder of FY 2014 through FY 2017 total \$17.6 billion. This funding would address challenges such as clinical staff, space, information technology, and benefits processing necessary to provide timely, high-quality care and benefits.

Working With VSOs

I appreciate the hard work and dedication of our VSO partners—important advocates for Veterans and their families—our community stakeholders, and our dedicated VA volunteers. I have conducted more than 15 meetings and calls with senior representatives of VSOs and other stakeholder groups to solicit their ideas for improving access and restoring trust. Just 2 weeks ago, I met with the leadership of 26 Military Service Organizations (MSO) and VSOs to reaffirm VA's commitment

to work together to address the unacceptable, systemic problems in accessing VA health care. During this meeting, I updated the organizations' representatives on VA's work to restore Veterans' trust in the system and on VA's progress in reaching out to get Veterans off of waiting lists and into clinics.

MSOs and VSOs are VA's valuable partners in serving Veterans and continuing to improve the Department. I am grateful for their ideas on how VA can improve Veterans' access to care and services. VA particularly appreciates a longstanding and ongoing partnership with the excellent Veterans organizations that focus on specialized services and rehabilitation programs to ensure that VA continues to give priority to providing these services and programs for disabled Veterans (e.g., spinal cord injury, blind, amputees, polytrauma). In addition, we embrace partnerships with all of the service organizations that help us to keep our compass pointed in the right direction. I meet regularly with MSOs and VSOs to share information and solicit their input.

Similarly, I have directed medical center Directors to meet with their local MSOs and VSOs on a monthly basis to ensure we have the benefit of their perspectives from the local as well as the national level.

Working With Congress and the House Committee on Veterans' Affairs

I also respect the important role Congress and the dedicated Members of this Committee play in serving our Veterans. I look forward to continuing our work with Congress to ensure Veterans have timely access to the quality health care they have earned.

As I stated to you when I appeared before the Committee in April, for the benefit of our Veterans, the status quo in our working relationship must change. My perspective then was that we as a Department must and can do better—and my assessment has not changed. I remain convinced that our Veterans are best served when the Veterans' Affairs Committees and the VA work together in a collaborative and constructive manner.

The Department will continue to work openly with Congress and to provide information in a timely manner. VA's participation in 18 congressional hearings in June and July demonstrates our commitment in support of Congress' oversight role. I specifically acknowledge the need to improve the timeliness of our responses to congressional inquiry. We will continue our efforts to improve and to build our relationship with Congress in order to restore trust.

Conclusion

We understand the seriousness of the problems we face. We own them. We are taking decisive action to begin to resolve them.

The President, Congress, Veterans, VSOs, the American people, and VA's staff all understand the need for change. We must—all of us—seize this opportunity.

We can turn these challenges into the greatest opportunity for improvement in the history of the Department.

I believe that in as little as 2 years, the conversation can change—that VA can be the trusted provider of choice for healthcare and benefits.

If we are successful, who wins? Veterans will be the clear winners if we can meet, overcome, and prevail in the challenges and issues VA is facing. That includes the growing number of Veterans that turn to VA for healthcare each year; the 700,000 Veterans who are currently diagnosed with PTSD; the million Iraq and Afghanistan Veterans that have turned to VA for healthcare since 2002; and, the average Veteran who turns to VA for healthcare who is older (50 percent over age 65), sicker (many have multiple and serious chronic conditions), and poorer (60 percent have less than \$20,000 income), than average patients in the private sector.

Those are the Veterans who will win when VA becomes the trusted provider of care and benefits. That is what, and where, we want to be—in the shortest time possible. Our ability to get there depends on our will to seize the opportunity, challenge the status quo, and drive positive change.

I appreciate the hard work and dedication of VA employees, the vast majority of whom care deeply about our mission, want to do the right thing, and work hard every day to care for Veterans. As well, I appreciate our partners from Veterans Service Organizations, our community stakeholders, and dedicated VA volunteers.

Last, I deeply respect the important role that Congress and the members of this committee play in serving Veterans, and I am grateful for your long-term support.



STATEMENT OF
VERNA JONES, DIRECTOR,
VETERANS AFFAIRS AND REHABILITATION DIVISION OF
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"RESTORING TRUST: THE VIEW OF THE ACTING SECRETARY AND THE
VETERANS COMMUNITY"

JULY 24, 2014

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JULY 24, 2014

The American Legion, on behalf of our National Commander Daniel Dellinger and the 2.4 million members across this nation, are here to reaffirm our commitment to building a strong VA to serve the needs of this nation's veterans. Our organization has been critical of VA both prior to, and throughout this crisis, and we will continue to scrutinize VA, not because we dislike or oppose the Department, but because we are fiercely devoted to ensuring veterans receive only the best from the cabinet level department designated to serve them.

Nearly one hundred years ago, The American Legion was chartered by Congress to fight for veterans. We led the charge for the GI Bills; both the original GI Bill that enabled the boom years of the 20th Century, and the Post 9-11 GI Bill that will pave the way for a greater America in the 21st Century and beyond. We've fought for advanced funding for VA for long term budget planning and we've argued for greater construction budgets. We even pointed out that VA's requests in past years, as simple math illustrated, their budget requests set a pace to finish VA's ten year construction plan in sixty years.

What Are We Doing? – The Veterans' Crisis Command Centers:

As the veterans' healthcare crisis scandal spread nationwide this year, The American Legion quickly realized the true impact of the scheduling problems – veterans across America were suffering and dying due to delayed access to healthcare. In response to this crisis The American Legion immediately organized Veterans Crisis Command Centers (VCCCs) in critically affected areas throughout the country, in conjunction with local American Legion Posts, and local resources, to address the needs of veterans.

To date, The American Legion has run VCCCs in five cities with two more scheduled this week, and half a dozen more to follow over the next three months. Simultaneously, we conducted a System Worth Saving (SWS) Task Force meeting and veteran's town hall in Indianapolis Indiana where we worked with nearly 100 local veterans, followed by a visit to the Roudebush VA Medical Center. While the purpose of the VCCCs is to provide a broad variety of support to meet the complex needs of the veterans in these communities, mental health remains a critical component. VCCCs have been able to put veterans and their families in touch with grief

counselors when loved ones have been lost due to delays in care, as well as Vet Center counselors to deal with mental health problems such as PTSD and depression.

The American Legion has been able to reach about 2,300 veterans in Phoenix, Arizona; Fayetteville, North Carolina; El Paso, Texas; St. Louis, Missouri; and Ft. Collins, Colorado. American Legion national staff worked in conjunction with personnel from the National Veterans Legal Service Program (NVLSP), VA personnel, and staff from both sides of the House Committee on Veterans' Affairs (HVA), and other local service providers, to provide help with claims, VA enrollment, basic health screening, and counseling. By directly engaging with VBA staff, The American Legion has been able to help veterans receive over half a million dollars in back pay and previously delayed benefits. Local American Legion Posts provide the backdrop for Town Hall meetings upon arrival in the new locations, providing veterans with an opportunity to communicate directly with our staff and VA officials in the area. VA is then able to communicate back to the veterans regarding how they are addressing the concerns and rectify the mistakes that have been made.

These VCCCs work because of the ability to engage the entire community to meet the needs of veterans. The American Legion has over 14,000 posts nationwide and there is one in almost every community in America. By engaging these posts the American Legion is engaging the *community* to help VA meet the challenges. We reach past the blame game and start finding the solutions to these challenges in partnership with the community, because this assistance will be critical as all stakeholders work to find solutions to the VA crisis. You cannot find effective, long-lasting solutions without organically including all stakeholders from the beginning. We are all in this together.

Waiting For Care – The VHA Crisis:

As this year has progressed, revelations from the Department of Veterans Affairs (VA) Office of the Inspector General (VAOIG) have made it clear that there have been serious lapses in leadership, which has resulted in VA's struggle to provide timely and appropriate care. Appointment concerns that veterans have noted for years – such as having problems getting appointments and care from VA – are now well documented.

Veterans groups, as well as members of this committee have faced these same challenges in their districts. In El Paso veterans told Congressman O'Rourke they couldn't access mental health care despite VA telling him that veterans were waiting no longer than 7-14 days for appointments. He decided to stop listening to the self reporting from VA and go directly to the veterans, contracting a survey of the veterans in his district. What he found confirmed that the veterans in his district had a right to be frustrated. While El Paso VA reported "85-100 percent of new patients to the system seeking mental health appointments saw a provider within 14 days" the survey results showed "on average it takes a veteran 71 days to see a mental health provider

and more than 36 percent of veterans attempting to make an appointment were unable to see a mental health provider at all¹.”

These discrepancies, coupled with what has been revealed across the country, show that VA’s published statistics are to be viewed with some skepticism. While The American Legion appreciates that VA is making an effort to reverse long standing trends of false reporting of statistics, change of this kind does not happen overnight.

According to current figures² the average wait time for a new patient to be scheduled an appointment are as follows:

- Primary care Average waiting time - 46.64 days,
- Specialty Care Patient Average wait time - 49.39 days
- Mental Health Average wait time – 35.20 days

VHA has made strides reducing new patient wait times, but these numbers continue to remain unacceptable. Veterans should not have to wait on average over a month to schedule an appointment. On July 11, 2014, staff from The American Legion participated in a conference call with VA staff to discuss the progress and current make-up of the veterans who have been languishing on wait lists. When asked if all of the veterans who were previously identified as being placed on a list other than the Electronic Wait List (EWL) have been moved to the EWL, Mike Davies, National Director, of System Redesign assured representatives from The American Legion that all veterans have now been moved to VA’s EWL. This is progress and a first step towards transparency. In order to even begin to understand the problem, there has to be a clear understanding of the scope involved.

In the July 1, 2014 edition of the VA Access Data report, total appointments scheduled were noted to be 6,016,910 of which 5,375,660 were scheduled within 30 days. This gives an under 30 day appointment rate of 89.34 percent. It is still unclear how 89 percent of appointments can be scheduled within 30 days, yet the average wait times for appointments all exceed 35 days, but these statistical questions will all need to be resolved as VHA moves closer to accurate data. The American Legion remains committed to closely monitoring such trends until accurate numbers begin to resolve.

This recent crisis has demonstrated that VHA has not done a good job in outsourcing health care outside the VA health care system. Over past years, VHA has implemented numerous pilot programs, such as Project HERO, Project Access Received Closer to Home (ARCH), and Patient-Centered Community Care (PC3). The Project HERO dental contract ended September 30, 2012. The Project HERO medical contract ended March 31, 2013. Project ARCH contracts

¹ <http://orourke.house.gov/sites/orourke.house.gov/files/VAFinal6-3-2014.pdf>

² http://www.va.gov/HEALTH/docs/VAMC_Patient_Access_Data_20140717.pdf

are due to expire in September of this year and PC3 was rolled-out in January 2014. While some of these projects, such as Project ARCH, have received positive reviews from veterans, commitment from VHA has been tepid in some cases. Despite veterans who reported high satisfaction with ARCH, The American Legion found VHA did a poor job with outreach, and in many cases, the program was underutilized because not enough patients knew about the project³.

Outsourcing care is like any other tool in VHA's toolbox. The end goal is securing adequate and timely care for veterans. In the aforementioned July 11th conference call with VHA, it became clear that less than 20 percent of the veterans waiting in line for appointments were waiting for at primary care appointment. Therefore, in approximately 80 percent of the cases, VHA already had the authority to outsource the care if they couldn't meet the veterans' needs in a timely manner. While legislative fixes will help, especially with veterans who haven't even made basic primary care appointments, the tragedy of the wait time scandal is that VHA had and continues to have the authority to get care for most of these veterans.

Waiting in Line – The VBA Backlog Crisis:

When a panel of whistleblowers addressed this committee last week on July 14th 2014, their stories of cutting corners, manipulated numbers, and missing veterans' data was eye popping to some, but not to The American Legion. Much as Congressman O'Rourke found discrepancies in what was being reported as compared to what his constituents were telling him, The American Legion has long found that accuracy figures on VA claims do not match up, or in some cases even come close. Our National Commander Daniel Dellinger noted in his address to the joint House and Senate Veterans Affairs Committees last September and again in May of this year that VA claims of accuracy figures of over 90 percent seemed high, when American Legion ROAR visits routinely found accuracy rates to be closer to 75 percent or below⁴. Testimony from the VAOIG on July 14th found error rates far closer to American Legion figures while examining VA's recent initiative of "claims pending over two years"⁵. Looking at these claims, VAOIG found an accuracy rate of 68 percent, 32 percent of claims had errors. During one regional office visit in 2014, we addressed this concern with a senior VA official; he reported it was unfair to assign blame to a current rater or VA Regional Office (VARO) for an inaccurate decision made years in the past; however, each rater is required to conduct a thorough review of each veteran's claims, to include previous adjudications. It has become increasingly clear that VA's objective is to protect its employees – The American Legion's objective is to protect the veteran.

After strong pushback from VA regarding accuracy figures, Undersecretary for Benefits Allison Hickey recently announced VA is seeking outside, third party evaluation of their statistics. As announced in the hearing, VBA is moving towards "ISO 9001" certification, based on standards

³ <http://www.legion.org/sites/legion.org/files/legion/publications/sws-rural-healthcare-report-2012-web.pdf>

⁴ <http://www.legion.org/sites/legion.org/files/legion/publications/Commanders-Testimony-2013-WEB.pdf>

⁵ <http://www.va.gov/oig/pubs/VAOIG-13-03699-209.pdf>

developed by the International Organization for Standardization. The American Legion appreciates that VBA has finally recognized the legitimate skepticism of stakeholders towards their numbers, but with that, the move towards ISO 9001 certification does raise legitimate questions about VA's belief in their own system.

In a VSO briefing addressing the ISO 9001 certification, the stakeholders were told by VBA that "the gold standard" for manufacturing is 96 percent accuracy, and for the service industry, where VBA more accurately falls, the gold standard rate is approximately 95 percent without a massive influx of new employees to change the worker ratio. In light of this information, achieving former VA Secretary Shinseki's stated goal of 98 percent accuracy seems unrealistic and unattainable, and The American Legion would be skeptical of reported results that showed 98 percent accuracy had actually been achieved. VA has admitted that the 14 day goal for treatment in VHA was arbitrary and unrealistic, and it is important to recognize that the achievement of some aspirational goals, numerically, are not as important as actually changing the way VA does business.

If VBA could produce "gold standard numbers", independently verified for accuracy, veterans could have confidence that their claims were being processed with acceptable error rates. The American Legion hopes VBA is attacking this problem, not with the aim of meeting an arbitrary number – like the 98 percent figure plucked out of the air five years ago – but with the ultimate goal of getting claims done right the first time and every time.

When claims aren't processed right the first time, the real waiting period in the claims backlog begins – appeals. When VA inaccurately processes a veteran's claim, that veteran is forced to appeal the claim. Suddenly, a process that took a dozen months starts to drag into half a dozen years. While VA has flown through the backlog of claims in recent months, issuing hasty decisions as they cut the backlog in half, they have also seen skyrocketing numbers in terms of appeals. Recent figures show over 279,000 claims on appeal⁶, while in 2009 when then Secretary Shinseki initiated the war on the backlog, there were only 173,000⁷. That's an increase of almost two third the total appeals inventory volume. Furthermore, as the more experienced and seasoned Decision Review Officers (DROs) are pulled off appeals work, as they have been in some offices to work initial claims, the wait for veterans with claims on appeal will only get exponentially longer.

In April 2013, VA pursued a one and two year old claims initiative. The initiative was coupled with the provisional rating program detailed in VBA Fast Letter 20-13-05 (April 2013). According to the instruction, VA regional offices were to issue provisional rating decision even if VA was still awaiting certain evidence. Raters would adjudicate the claims based on the available evidence of record unless the requests for evidence is outstanding pertain to:

⁶ VA Monday Morning Workload Report – July 7, 2014

⁷ VA Monday Morning Workload Report – July 20, 2009

- Service treatment records for original claims
- VA medical records
- Any evidence needed to establish veteran status and/or pertinent service dates
- VA examinations, if examinations are pending at the time the case is reviewed or if one is required to adjudicate a claim

When VA instituted this program, The American Legion feared that this was a method used to reduce the appearance of the backlog as it appears on the Monday Morning Workload Report (MMWR), while not truly addressing the backlog. In short, it was a method to remove the case from the backlog figure, while VA continued to develop the claim. An unfinished claim would no longer count against their numbers because a provisional decision was then counted as a completed claim.

In November 2013, we received two rating decisions from the Seattle VARO. A September 2013 decision stated, “VA examinations have not been conducted yet; once conducted and received we will review them and if service connection is warranted we will reconsider our decision.” A separate decision prepared the following month stated, “Your service treatment records are unavailable for review. Therefore, we do not have any evidence of an in-service event. Your VA treatment records show you reported depression in August 2011 and stated that you have felt depressed since your Gulf War service. Once your service treatment records are reviewed, this decision will be reconsidered. You will be notified when a decision is made.”

These rating decisions are two examples of VBA’s inability to comply with the April 2013 Fast Letter. VBA assured the public in an April 19, 2013, news release that “if a VA medical examination is needed to decide the claim, it will be ordered and expedited. The rating decisions provided by the Seattle VARO amount to little more than a letter issued by VA indicating their continued work on the veteran’s claim with one exception – VA was presumably able to receive an end product for these decisions and will get another end product when the decisions are rendered with the appropriate level of evidence.

While VBA continually touts its improvement in its backlog, we must realize this does not fully include all veterans awaiting a decision. MMWR figures only consider the following claims when calculating its backlog:

- Initial entitlement for service connected disability
- Initial entitlement for pension
- Initial claims for surviving dependents

The MMWR fails to consider:

- Award adjustments such as dependency claims
- Program reviews
- Other compensation reviews
- Pension adjustments
- Pension program reviews
- Other pension reviews
- Appeals

According to their own data⁸, VA reported a backlog 291,740 claims; however, this does not include all of the claims in VA's inventory

- Award adjustments such as dependency claims (305,788)
- Program reviews (53,416)
- Other compensation reviews (129,628)
- Pension adjustments (17,291)
- Pension program reviews (24,944)
- Other pension reviews (2,314)
- Appeals (275,181)

Combine VA's acknowledged backlog exceeding 291,000 claims with the remaining claims VA has chosen not to place in its backlog statistic, 1,100,302 claims are awaiting a decision. While VA has made improvements to its backlog, the reality is that the statistic generated by VA only comprises a quarter of the reality of the claims awaiting adjudication.

The Way Forward – Changing the Culture in VA:

When the problems of VA are viewed in total, several trends become clear. The guilty are not held accountable. Those who speak out against the system, be they employee or deeply concerned stakeholders, are vilified and shouted down. There is an institutional predilection against change and against responsibility.

To increase accountability, Congress can pass legislation to give the Secretary of VA the needed authority to fire and discipline senior leadership for failure to perform to standards. It is mind boggling that VA would claim they lacked authority to discipline the leadership in multiple

⁸ Monday Morning Workload Report May 26, 2014

locations responsible for patient deaths due to preventable mistreatment. That is why The American Legion supports legislation such as the VA Management Accountability Act and similar legislation that gives the VA Secretary the tools needed to clean out bad actors in the system⁹.

Furthermore, this authority should extend to those leaders and staff who harass and torment those brave employees who raise questions and come forward. Whistleblowers will only be free from fears to come forward when they see consequences implemented against leaders who have harassed those who have already spoken out. Acting Secretary Sloan Gibson has rightly stated that there is no place in VA for those who would harass whistleblowers. However, witness testimony from whistleblowers indicates this punitive behavior is still going on. It's time to make sure policy actions match that statement and see consequences for those who bully and intimidate employees to prevent them from speaking out to make VA a better place for veterans.

To increase transparency, VA can improve their figures by submitting to outside, third party oversight, as they claim they are ready to do. They can treat veterans or employees who point out discrepancies in their figures not with retaliation, but with dialogue and understanding. They can recognize that we all work better when we work in partnership. While VA is quick to tout the benefits of VSOs in helping achieve goals through programs like the Fully Developed Claims (FDC) initiative, they close the door on VSOs when those organizations question error rates. That's not partnership, and that attitude cannot continue.

We get the best results *for veterans* when we all work together.

Last week, while appearing before the Senate Committee on Veterans Affairs (SVAC), Acting VA Secretary Sloan Gibson made a plea for an additional \$17.6 billion over the next three years to address the critical access needs for America's veterans. The American Legion is taking this request seriously. As Senator Jon Tester (MT) pointed out in that same hearing "[Montana] is short 22 physicians, you can't make up all of those physicians just with efficiencies." There will be additional resources needed for VA, and Congress should not balk at the cost to care for our veterans, where such funding is needed.

However, at the time of this testimony, VA has still been unable to provide more than rough estimates of where that funding would go and many questions still remain. Billions are requested, and likely needed in construction funding, yet The American Legion remains skeptical of VA's ability to manage funds in their construction accounts, as their current four major projects in Colorado, Nevada, Florida and Louisiana have all spiraled out of control. There are absolutely areas where VA will need more physicians and professionals to meet their needs, as Senator Tester pointed out, however there are other areas where it is apparent that resources may not be being managed to their best potential, such as those pointed out by Jose Matthews, MD,

⁹ Resolution No. 14: *Department of Veterans Affairs Accountability*, MAY 2014

former Chief of Psychiatric Medicine in the St. Louis VA Health Care System in his testimony before this committee¹⁰.

Furthermore, Acting Secretary Gibson's emergency supplemental request encompasses a multi-year funding request that should have been addressed through, and during the VA's annual budget request to congress. All of the resources now being requested by VA are exactly what The American Legion has been telling VA and congress for years, and should have been forecasted accordingly. Emergency and supplemental requests are generally used for current fiscal year deficiencies. The American Legion is having trouble understanding why out year funding requests aren't being requested through the normal budget request process. And finally, this committee and the conference committee assigned to work on HR 3230 needs to be able to evaluate how much of this request would overlap with the scored scenario published by the Congressional Budget Office. If VA already has the statutory authority to serve 80 percent of the veterans waiting for VA care, then HR 3230 would only need to address the remaining 20 percent. If Mr. Gibson's budget request addresses the other vast majority of the waitlisted veterans, and works to build VA infrastructure so that it is able to address the larger than expected influx of returning veterans waiting to use VA care, then the committee will need to consider a hybrid solution that considers the best of both proposals.

Acting Secretary Gibson also told SVAC that VA would have to earn back the trust of each and every veteran, and part of that trust means full disclosure to the stakeholders. Gibson admitted he would not be shy about asking for the resources he needed, but promised there would not be a penny asked for that was not needed. Veterans need to trust, but verify. The American Legion looks forward to working with VA to determine where there is additional need to serve America's veterans, then to fight fiercely for it against those who would deny VA the resources it needs. For additional information regarding this testimony, please contact Mr. Ian de Planque at The American Legion's Legislative Division, (202) 861-2700 or ideplanque@legion.org.

¹⁰ <http://veterans.house.gov/witness-testimony/jose-mathews-md>

PREPARED STATEMENT OF RYAN M. GALLUCCI

Mr. Chairman and Members of the Committee:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today on the current state of Department of Veterans Affairs (VA) health care and steps the VFW believes we need to take to restore trust and confidence in the VA health care system.

The recent events at the Phoenix VA Medical Center, the subsequent national audit of all VA facilities, and repeated whistleblower accusations of impropriety within VA have all shed light on major issues facing the VA health care system as it seeks to deliver timely, quality health care to our nation's veterans. Over the past three months, we have seen a VA Secretary and numerous deputies resign. We have also seen a newly-minted Acting Secretary working diligently to understand the situation on the ground at VA health care facilities across the country, seeking to expose systemic problems and prescribe corrective action.

The allegations made against VA over the past three months are outrageous, and the 1.9 million members of the VFW and our auxiliaries are rightfully outraged. However, the VFW also worries that the loss of trust among the veterans' community has the potential to be more harmful to our nation's veterans than much of the impropriety about which we have recently learned.

At the center of the recent scandal is the inability of veterans to receive timely care from VA. For more than a decade, the VFW has warned both VA and Congress about the potential dangers of long wait times and improper scheduling procedures. After Phoenix, we now know that these potential dangers were all too real.

When news of the scandal broke, the VFW knew that it had to intervene directly on behalf of veterans. We had no time to wait for VA to sort out its affairs through traditional channels, which is why we readvertised our health care help line, 1-800-VFW-1899, where veterans could turn for direct intervention on the VA health care concerns, or simply share their experiences to benefit their fellow veterans. Over the first two months of the outreach campaign for the VFW help line, we received more than 1,500 comments and complaints from our members, most of whom reported negative VA care experiences. The VFW worked directly with VA leadership to help resolve more than 200 critical health care issues most often related to oncology, gastroenterology, cardiovascular health or mental health.

In addition, the VFW sorted through all 1,500 comments to evaluate the current state of VA care and make specific recommendations to ensure VA never faces these problems in the future. For our testimony today, we will focus specifically on scheduling inefficiencies, non-VA care coordination, and the culture of accountability.

According to many of the veterans who contacted the VFW over the past two months, the major issue facing the VA health care system is timely access. Even veterans who relayed positive health care experiences still shared significant concerns over appointment wait times.

While some have sought to focus solely on the issues of access, appointment scheduling and care referral processes, the VFW has recognized that access to care is clearly linked to quality health care outcomes and customer service. Veterans who contacted the VFW often pointed to delayed diagnoses, worsening health conditions and hurried screenings for potentially serious health conditions when they could not receive appointments in a timely manner.

As the strain on the VA health care system continues to grow, the VFW's evidence also demonstrates that staff attitudes are rapidly deteriorating as veterans report doctors who shrug off serious symptoms during routine screenings and phone operators or clerks who treat veterans with contempt. It would be easy to single out these employees and blame them individually for their poor attitudes, low morale, and inadequate customer service. However, given the systemic scope of similar allegations across multiple VA health care facilities, the VFW believes that such poor staff attitudes indicate that the system is too strained to properly handle all of the veterans who require care.

After all of the recent scrutiny of the VA health care system, the VFW believes that we understand the problems now facing VA. However, we also recognize that there is no silver bullet solution to the current crisis. To the VFW, improper resourcing, archaic accountability standards, outdated technology, and inconsistent business practices have all contributed to the current crisis.

As we seek to resolve these issues, we must be careful not to dismantle the VA health care system or abdicate VA of its responsibilities to care for veterans. The VFW believes that the VA health care system is far too important, and many of its veteran-specific services cannot be easily duplicated in the civilian health care sector.

To the VFW, outdated appointment scheduling and tracking technology is central to the current crisis. Built and implemented in the 1980s, VA's appointment-scheduling software has not changed much over the years—except for the occasional patches and work-arounds designed to gather new information. Moreover, VA's systems that track incoming patients and specialty consults are only loosely linked to the scheduling system, meaning VA scheduling is rife with inaccuracies, allowing patients to easily slip through the cracks. VA has asked repeatedly for a new scheduling system, but IT funding shortfalls have made it nearly impossible to take the major steps of replacing a system-wide software platform.

VA also acknowledges that this antiquated, patch-work system makes it impossible to properly monitor the supply of available appointments. This means that VA cannot adhere to private industry wait time standards and also exposes the scheduling system to rampant fraud and manipulation, as evidenced by repeated VA memos to health care facilities chastising those who seek to game appointment scheduling. This also makes it nearly impossible for VA to manage the workload for its clinicians, meaning that some clinicians may be overworked, while others may be under performing. In either case, veteran care quality suffers.

One veteran who recently contacted the VFW shared his experience trying to transfer into the Salt Lake City VA Medical System. He told the VFW that when he tried to enroll, VA said it would take at least six months to see a primary care doctor. After six months, VA contacted the veteran again to inform him that it would take another six months to get an appointment. When the veteran followed up with VA, he was informed that he was disenrolled since he had not seen his primary care physician in more than a year. This is a clear failure of VA scheduling protocols and business practices. We have to do better. This is why the VFW calls on Congress to immediately provide VA with the resources necessary to acquire a modern and sustainable appointment-scheduling system that will allow patients to easily access appointments and allow VA to finally measure its workload and adapt accordingly.

Since the scandal broke, some in Congress have presented non-VA care as the best solution to ensure veterans can receive timely care. The VFW acknowledges that VA must fully leverage its authority to provide non-VA care to veterans when VA cannot provide direct care. However, VA still must have the responsibility and the resources to properly coordinate non-VA care and ensure that such care is delivered properly. The VFW also worries that the civilian health care system lacks sufficient capacity to deliver comparable care in a timely manner.

Earlier this week at the VFW National Convention, I had the opportunity to speak with a veteran's caregiver who recounted a recent nightmare in receiving non-VA care. The veteran who needed a seemingly-routine knee surgery was sent to a major outside health care provider for the procedure, since VA was backlogged for nearly two years to conduct the procedure in-house. While VA coordinated the care on behalf of the veteran, what followed was a bureaucratic nightmare for the both the veteran and his caregiver once the surgery was performed.

After the non-VA provider performed the operation, the veteran was quickly discharged and told that the civilian provider had no further responsibility for his convalescence. The facility discharged the veteran without providing a simple prescription for pain management associated directly with the procedure. In fact, the veteran and his caregiver had to immediately go from the non-VA facility to VA to receive proper convalescent medication and the requisite prosthetic devices that the veteran would need for recovery.

While the VFW understands that VA may have been best suited to provide both the medication and the necessary prosthetics, this was not properly communicated to the veteran prior to the procedure. Moreover, the veteran caregiver reported that the non-VA facility was inflexible in providing basic recovery services to the veteran while still in their care.

To the VFW, this is a prime example of why outsourcing VA care is not a catch-all solution to the current crisis. Must VA outsource care when they cannot deliver it in a timely manner? Absolutely. However, VA must continue to serve as the guarantor of such care, and it must be responsibly coordinated to ensure veterans have positive health outcomes.

The VFW has been fully supportive of VA's efforts to revamp its delivery of non-VA care through the creation of Non-VA Care Coordination (NVCC) teams and the implementation of the Patient-Centric Coordinated Care (PC3) program. NVCC teams are charged with coordinating non-VA care on behalf of veterans who cannot receive adequate care from VA. While the VFW supports the concept of NVCC, Congress must ensure that NVCC teams are properly staffed with professionals capable of making responsible, timely health care decisions. PC3 is VA's new program designed to deliver coordinated non-VA specialty care through established civilian

health care networks. PC3 is a program that the VFW believes can make a difference, but we caution that Congress must have proper oversight of how PC3 works and whether referrals through PC3 can deliver timely care.

While VA must properly leverage non-VA care, the VFW also recognizes that the challenges VA faces in tracking and scheduling appointments immediately affects VA's ability to refer veterans to non-VA providers in a timely manner.

The VFW also worries that accountability issues within VA present major, multifaceted problems. While the VFW has supported legislation to ensure the VA Secretary can easily sanction executive-level employees, we also acknowledge that accountability is a major issue at all levels in VA's chain of command. To the VFW, allegations of under performing and apathetic employees is likely the result of a bureaucratic culture in which VA cannot efficiently reprimand or terminate poor-performing employees; or hire quality new employees in a timely manner.

When then-VA Secretary Eric Shinseki was pressed by the Senate over how many employees he had fired under his watch, Shinseki acknowledged that very few of the 3,000 employees reprimanded had a significant adverse personnel action taken against them, such as demotion or termination. Moreover, VA has repeatedly acknowledged that the hiring process for new employees takes between six months to a year.

This prompted the VFW to ask whether or not VA managers make trade-offs in evaluating employee performance. The VFW believes that if VA has a poor-performing employee, the current system incentivizes retaining that poor-performing employee in lieu of initiating the laborious process of terminating the employee, then finding a quality replacement.

The hiring process makes it even more difficult for VA to properly staff its facilities. Veterans have consistently reported to the VFW that staffing shortages and high turnover, even among clinicians, has contributed to current access issues. To make this situation worse, VA simply cannot compete with the private health care sector when it seeks to hire new clinicians. Private health systems can hire new clinicians in a matter of days and weeks. So even if a doctor wants to work for VA, the VFW recognizes that many doctors cannot wait six months to a year for VA to follow through. If VA cannot quickly fill its vacancies with top talent, we cannot expect VA to properly reprimand poor performers. If VA cannot reprimand poor performers, we cannot reasonably expect VA to deliver timely, quality care to the veterans who need it. This will take significant changes to federal employee protections and federal hiring practices, but the VFW believes that this can be done equitably to provide reasonable protections for employees, but decisive accountability for under performers.

The VFW is also concerned that for far too long VA has focused on its internal business models rather than the needs of its end-users, the veterans. In other words, in accomplishing its mission, VA does what is best for VA, instead of what is best for the customer. The VFW believes that this culture must change.

To the VFW, the culture of secrecy and low morale among VA employees are symptoms of a VA culture that does not focus on the well-being of patients. The VFW has heard concerns from veterans that resources are stretched too thin, but employees are afraid to speak up. In this environment, if doctors are forced to rush treatment, they will naturally misdiagnose their patients or botch a critical procedure. Doctors will also burn out and leave VA—especially when hospital administrators downplay or neglect the legitimacy of their concerns.

To make this situation worse, inspectors have found clear examples where whistleblowers who exposed inadequate care standards or disingenuous business practices were quickly penalized for speaking up. Instead of incentivizing proper care or patient safety, the business mind-set of VA seemed to encourage employees to cut corners in order to make the system work.

VA has to change this business mind-set. Administrators and clinicians must recognize that their primary mission is serving veterans—not VA. Congress must also ensure that VA employees at all levels feel comfortable asking for help or voicing their concerns to leadership when the situation demands it.

Finally, the VFW has repeatedly heard from veterans that VA Patient Advocates are incapable of directly intervening on behalf of veterans at many VA health care facilities. Some veterans even quipped that Patient Advocates do not advocate for the patients; they advocate for VA. The Patient Advocate is designed as the primary method of recourse for a veteran to resolve health care issues locally. They are supposed to be able to intervene directly with either hospital directors or care providers. However, veterans have told the VFW that Patient Advocates often lack the authority to perform their most basic functions. VA Patient Advocates must be appropriately staffed with professionals capable of intervening on behalf of veterans. They

must also have the institutional support of VA leadership to intervene in difficult circumstances.

As you can see, the current problems in VA are multifaceted and demand decisive reforms. Thankfully, not everything the VFW hears about VA health care has been bad. Nearly 40 percent of the veterans who contacted us to share their health care experiences praised the care they received at VA. At the recent VFW National Convention, several veterans sought out our national staff to share their stories on how VA doctors had saved their lives. Others offered their perspective on how much the VA health care system has improved over the last three decades. We believe the system can work, but it cannot work unless Congress takes action.

This week at the VFW National Convention, the membership of our organization passed a stern resolution calling on Congress to quickly pass the VA Access and Accountability Act that currently sits in conference. Though this bill will not solve all of VA's current woes, both the House and Senate have already agreed that these necessary reforms will help veterans receive the care that they need. Congress absolutely cannot go into the August recess without passing this bill. When the current VA scandal broke, every legislator agreed that this was a national imperative. However, in recent weeks, some legislators have backed off, caring more about the cost of the legislation than the veterans who are waiting for care. This week, the members of the VFW said this is unacceptable. If Congress fails to pass this legislation before the recess, our members will hold their representatives accountable during the August recess.

We have an opportunity here. We have an opportunity to show our veterans and the men and women still serving in harm's way that our nation will live up to its promise to care for those who defend our way of life. We have to get this right. We have to restore trust and confidence in the VA system, and the VFW will do whatever it takes to make that happen.

Mr. Chairman, this concludes my testimony and I am prepared to take any questions you or the committee members may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

PREPARED STATEMENT OF CARL BLAKE

Chairman Miller, Ranking Member Michaud, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the current state of health care provided by the Department of Veterans Affairs (VA), the changes that have been made by the VA in the wake of serious access problems that have been reported in recent months, and additional changes that we believe are warranted moving forward. PVA members—veterans with spinal cord injury or dysfunction (SCI/D)—have the unique perspective of dealing with a system of care within the VA that is wholly dedicated to their health care needs. No group of veterans understands the full scope of care provided by the VA better than our members. PVA members are the highest percentage of users among the veteran population. They are also the most vulnerable when access to health care and other challenges impact quality of care.

Yet, as the VA has made significant changes to address the nationwide access problems facing the system, and as Congress continues to debate legislation to address these problems, the specialized health care needs of our members, and other veterans with catastrophic disabilities—loss of limbs, blindness, polytrauma and traumatic brain injury, etc.—have been all but ignored. The simple truth is the VA is the best health care provider for veterans.

VA Accelerated Access to Care Initiative

As you are aware, immediately following the media reports about the serious access problems at the Phoenix VA Medical Center (and other facilities around the country), the VA instituted the Accelerated Access to Care Initiative. Through this program, VA will reach out to all veterans it has identified who have waited longer than currently established access standards to provide them the first available appointment within the VA health care system or immediately seek care in the community. This program essentially reflects an expansion of fee-basis care authority. PVA has long argued that VA does not do a good job of managing its fee-basis authority or ensuring that the care provided is properly coordinated with VA

providers. Hospital directors and Veterans Integrated Service Network (VISN) directors were incentivized to use fee-basis care as little as possible as a part of their performance evaluations. As a result, veterans were often denied access to fee-basis care even when it was appropriate, leaving veterans waiting longer than necessary for care or traveling great distances to receive care.

We believe that the steps being taken to expand access to care through this initiative are appropriate. However, we believe that VA should focus on many of the concepts outlined by its Patient-Centered Coordinated Care (PCCC) program as it expands contract care options. The PCCC program places the responsibility for management and coordination on the VA, but it also places specific requirements on its contract partners regarding veterans' medical records and follow-up prior to guaranteeing payment.

As the VA has rolled out this initiative, many of us in the veterans service organization (VSO) community have heard that many of the solicitations to veterans to provide service through this program continue to be haphazard and not well managed. We are certain that this is not the intent of the Veterans Health Administration (VHA), but the only way to ensure success is to overcome these types of concerns. We would encourage the Committee to conduct serious oversight of the Accelerated Access to Care Initiative to ensure that high quality health care is provided in a timely manner and that it is managed in a well-coordinated and reasonable manner.

Providing Veterans a Choice for Health Care

As a result of the serious scrutiny that the VA Health Care System has been under in recent months, Congress is moving on a bipartisan basis to expand contract care activities within the VA to address the problems that have been identified. We continue to reiterate the fact that the VA's specialized services—spinal cord injury care, amputee care, blinded care, polytrauma care, etc.—are incomparable resources that cannot be duplicated in the private sector. Moreover, establishing a scenario whereby veterans can choose to leave the VA Health Care System places the entire system at risk. Former VA Secretary Anthony Principi recently wrote in the *Wall Street Journal* why the concept of a veterans' card (as provided for in the "Veterans Choice Act") is not a viable long-term solution to the problems facing the VA Health Care System:

"Vouchers (similar to cards) are not necessary to ensure high-quality health care .1A.1A. While this may have value in areas with long waiting lists, it raises serious questions. The VA system is valuable because it is able to provide specialized health care for the unique medical issues that veterans face, such as prosthetic care, spinal-cord injury and mental-health care. If there is too great a clamor for vouchers to be used in outside hospitals and clinics, the VA system will fail for lack of patients and funds, and the nation would lose a unique health-care asset."

These services do not operate in a vacuum. The viability of the VA Health Care System depends upon a fully integrated system where all of the services support each other. Sending veterans into the private health care marketplace serves only to undermine this principle. However, as Congress and the Administration move forward with broader contract care, it is important that VA remain responsible for coordinating and managing that care.

To be clear, PVA finds it wholly unacceptable that tens of thousands of veterans have waited for far too long to be seen for an appointment, and in many cases were never seen. We fully understand the intent of H.R. 4810, the "Veterans Access to Care Act," and similar legislation that is being considered by the conference with the Senate Committee on Veterans' Affairs. However, we have raised many questions as it relates to these bills in the past that we believe continue to be unanswered:

- How will continuity of care, seamless medical record exchange, and accountability be ensured when non-contracted, non-VA providers are added to a veteran's circle of care?
- What actions will Congress take when doctors choose not to accept veterans as patients because they choose not to accept the Medicare rate (a common and growing problem in the medical provider community)?
- How will Congress respond when reimbursements to private providers are not provided in a timely manner?
- What actions will Congress take when it becomes apparent that the private sector cannot provide timely access to high-quality care as well?
- What actions will Congress take when it becomes evident that the care being provided in the private sector is substandard to the VA?
- Will Congress provide the additional funds that will be absolutely necessary to support such a program when it becomes apparent that the cost of care pro-

vided in the private sector is significantly more expensive than care currently provided in the VA system?

Unfortunately, for those clamoring for it, contract health care is not the answer to this problem. Studies have shown that contract health care providers cannot provide the same quality of care as the VA at any less cost, despite claims by some that it can. Similarly, contract care simply is not a viable option for veterans with the most complex and specialized health care needs. A veteran with a cervical spine injury whose autonomic dysreflexia was mistakenly treated as a stroke is not better served at a local outpatient clinic or the local doctor's office closer to his or her home. Sending those individuals outside of the VA actually places their health at significant risk while abrogating VA of the responsibility to ensure timely delivery of high quality health care for our nation's veterans. This is not to suggest that leveraging coordinated, purchased care is not part of the solution to access problems in the VA. However, granting easier access to the private sector should not come at the expense of the existing health care system and the men and women who rely almost solely on the VA for their health care.

Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. These services were initially developed to care for the complex and unique health care needs of the most severely disabled veterans. The provision of specialized services is vital to maintaining a viable VA Health Care System. The fragmentation of these services would lead to the degradation of the larger VA health care mission. With growing pressure to allow veterans to seek care outside of the VA, the VA faces the real possibility that the critical mass of patients needed to keep all services viable could significantly decline. All of the primary care support services are critical to the broader specialized care programs provided to veterans. If primary care services decline, specialized care is then also diminished.

Understanding VA Capacity: Utilization vs. Demand

PVA has a unique perspective on the issue of capacity. In order to better track these issues and ensure they are addressed by the VA, PVA developed a memorandum of understanding with the VA more than 30 years ago that authorizes site visit teams managed by our Medical Services Department to conduct annual site visits of all VA SCI/D centers (hubs) as well as medical centers (spokes) that support the hubs. We are able to clearly identify where inadequate capacity exists in the SCI/D system. This opportunity has allowed us to work with the Veterans Health Administration (VHA) over the years to identify concerns, particularly with regard to staffing, and offer recommendations to address these concerns. What's more important, PVA is the only VSO that employs a staff of licensed physicians, registered nurses, and architects to conduct these visits and report on the conditions. Unfortunately, this concept is not easily transferable to the larger VA Health Care System.

The fact is that the most common complaint from veterans who are seeking care, or who have already received care in the VA, is that access to care is not timely. PVA believes that VA's access issues result from the broad array of staff shortages within the VHA, which brings into question the VA's capability to provide care to veterans when it is needed—VA's capacity. Evaluating the capacity of the VA to care for veterans will require comprehensive analysis of veterans' health care demand and utilization measured against staffing, funding, and VHA infrastructure.

We believe that VHA capacity is currently based on skewed utilization versus true demand for services as ultimately revealed by systemic hidden waiting lists. For instance, a shortage of nurses within the SCI/D system of care has resulted in VA facilities restricting admissions to SCI/D centers (an issue that we believe mirrors the larger access issues that are being reported around the country). Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D centers and beds are consolidated, leadership is not able to capture or report accurate data for the average daily census—demand. The average daily census is not only important to ensure adequate staffing to meet the medical needs of veterans; it is also a vital component to ensure that SCI/D centers receive adequate funding. Since SCI/D centers are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans. Lack of transparency made it impossible to prove to the (disingenuously) skeptical senior VHA leadership that veterans were languishing on waiting lists despite growing empirical evidence to the contrary (as evidenced by PVA's site visits), field staff engagement with facility and VISN directors, frequent meetings between PVA national leadership and the Under Secretary of Health, and the co-authors of The Independent Budget.

Meanwhile, the VA has manipulated scheduling practices and uses inadequate staffing ratios to misrepresent the demand for VA health care services. Staffing models are flawed by an underestimation of SCI/D patient acuities and loose interpretations of SCI/D bed/staffing policy. This has had a downstream impact on adequacy of funding for new major and minor construction, which has been lacking over the past decade. Limited care alternatives for groups requiring specialized services, particularly veterans with SCI/D, amputations, blindness, and polytrauma/TBI, become even more limited as demand increases thus stretching existing VA capacity at the seams and impacting access and quality of care in many cases.

This is simply unacceptable. The statistics reflect the fact that many veterans who might be seeking care in the VA are unable to attain that care. We believe that these staffing shortages exist not only in the SCI/D system of care, but across the entire VHA. Therefore, we recommend that an evaluation of VA's capacity include a comprehensive analysis of VHA staffing needs to include the recently identified veterans who were denied care, or are on wait lists for primary care. We also recommend the VA conduct outreach in its specialized systems of care to identify eligible veterans in need of care and ensure that they have access to the VA.

Evaluating VA's capacity to provide care will require the VA's commitment to transparency and the implementation of policies, procedures, and systems that will allow for the collection of data that accurately reflect the demand for VA health care in primary care and specialty care, and specialized services. We appreciate the fact that Acting Secretary Gibson outlined a plan to expand clinical staff across the VHA last week. However, it is important that the mistakes of the past are not repeated if Congress chooses to provide additional funding to address the concerns outlined by the VA. It is imperative that the VA commit to hiring actual providers who are delivering services. Otherwise, capacity will continue to be insufficient to meet actual demand.

Last, as a result of P.L. 104-262, the "Veterans Health Care Eligibility Reform Act of 1996," the VA developed policy that required the baseline of capacity for the spinal cord injury/disorder system of care to be measured by the number of staffed beds and the number of full-time equivalent employees assigned to provide care (the basis for PVA's site visits today). This law also required the VA to provide Congress with an annual capacity report to ensure that the VA is operating at the mandated levels of capacity for health care delivery for all specialized services. Unfortunately, the requirement for the capacity report expired in 2008.

PVA has made reinstatement of this annual capacity report as a legislative priority for 2014. We would like to thank Rep. Jeff Denham for introducing H.R. 4198, the "Appropriate Care for Disabled Veterans Act." This legislation would reinstate this critically important capacity reporting requirement. The report affords the House and Senate Committees on Veterans' Affairs, and the veteran stakeholders, the ability to analyze the accessibility of VA specialized care for veterans in such areas as SCI/D, mental health, women's health, and polytrauma. We urge the Committee to consider this legislation as soon as possible. Additionally, while this legislation focuses on VA specialized services, such a reporting requirement for all of VHA every few years would allow VA and Congress to have a more accurate reflection of what is needed to maintain VA's Health Care System.

Structure of the Veterans Health Administration

The overall structure of the VHA has obscured accountability. By design (and perhaps intent), the current structure places too much unchecked power in the hands of the 21 loosely aligned VISN directors with little evidence of operational control and accountability at the VA Central Office level. The original vision for the VISN structure was an efficient management system with limited staffing that would allow the top leadership of the VHA to delegate responsibility for delivering services. Unfortunately, the VISN system has evolved into a costly model that has too many administrators and too much bureaucracy with not enough nurses, clinicians, and therapists to deliver actual services.

Legislation has been considered in recent years that would reduce the number of VISNs significantly. We believe that the concepts of those bills have serious merit. In fact, we believe the time has come for the VHA to streamline itself and realign to a sharper focused group of networks with greater control retained at the VA Central Office level. Meanwhile, we maintain the position that Congress should not dictate specifically how many VISNs should be established to operate the VA Health Care System. Congress is not the appropriate entity to determine the optimal organizational structure of the VA Health Care System. That decision should be left to health care administrators at the top of the VA who have experience with these matters. However, that does not mean that significant pressure should not be

brought to bear on VA management to make changes to the VISN structure, including reducing their numbers.

Paralyzed Veterans also has serious concerns with the organizational realignment of the Chief Consultants of the specialized services at the VA Central Office. Under previous leadership, the VHA separated the Under Secretary of Health and VA Secretary by management filters added within the hierarchy. In other words, the Chief Consultant for SCI/D previously reported directly to the Under Secretary of Health, but now he or she reports to the Chief of Patient Services who reports to the Deputy Chief Under Secretary who then reports to the Under Secretary for Health. This reporting structure distances senior leaders from subject-matter advisers and filters concerns, essentially making the chief consultant of SCI/D an adviser to an adviser to an adviser who has direct access to the Under Secretary. It has rendered consultants, who report under Policy (10P), ineffective as they have no practical impact on the Operations (10N) side of VHA.

This chasm between the operations and policy components of VHA creates variability and inconsistent interpretation of VHA policies, particularly in the SCI/D system of care. This has made it difficult to monitor compliance with directives on critical concerns, such as timely SCI/D patient transfer to hubs and administration of fee-basis care. It also muddles top-down, bottom-up communication and discourages lateral communication.

Last, the current organizational structure has allowed for plausible deniability when serious systemic problems are identified. Senior VHA leadership was shielded from accountability in the wake of Legionella-related deaths in Pittsburgh, and colonoscopy-related deaths in Columbia and Augusta. As it is, while the VA touts itself as “One VA,” it really is 21 VAs (the VISNs) that function autonomously. It is time for this to change.

Ongoing Problems With Prosthetics Procurement

The VA Prosthetic and Sensory Aids Service (PSAS) has created a prosthetics and surgical products contracting center within the VA Office of Acquisition and Logistics that is responsible for ordering prosthetic devices that cost \$3,000 or more. Additionally, the “warrant transition” process added layers of bureaucracy by inserting a corps of administrators and acquisitions staff member into the clinical process supposedly driven by patient needs. Similarly, VHA downgraded the Chief Consultant for Prosthetics to a National Director and reversed course on a procurement process that was flawed by its former underpinning to the Federal Acquisition Regulations.

The “warrant transition” process placed Title 38 U.S.C. §8123 authority for purchases above the micro purchase threshold of \$3,000 (customized wheelchairs, limbs, surgical implants, etc.) in the hands of contracting specialists instead of on-site purchasing agents, thus creating physical and temporal distance between veterans with special needs and those who authorize purchases to meet those needs. Senior VA and VHA leaders who have oversight of acquisitions and procurement have made marginal progress in attempting to refine this process that is merely adequate for many instead of the best possible process available for all.

Unfortunately, these changes have resulted in delayed delivery of prosthetic devices, the diminution of quality service delivery for disabled veterans, and prolonged hospital stays for veterans waiting for the prosthetic equipment that they need to safely move forward in the rehabilitation process. The implementation of the new warrant transition process has not unfolded as planned, and an increasing number of veterans are suffering the consequences, languishing in hospitals as in-patients, or at home without their much needed prosthetic equipment. The VA is not communicating effectively with veterans and stakeholders in the veterans community to learn of the various ways that this change is impacting veterans and the delivery of their care. PVA believes that VA’s “warrant transition” process deserves more attention than it is currently receiving, and we recommend increased Congressional oversight to bring attention to the negative outcomes that have resulted from this change and to identify ways to address the issues.

Although the “warrant transition” involves a small percentage of the total workload for the VHA, this change includes critical prosthetic devices such as artificial limbs, wheeled mobility chairs, and surgical implants. Delays in these procurements prove costly to both the government, in terms of unnecessarily extended hospital stays while awaiting equipment, and veterans, in terms of lost independence and quality of life.

VHA Rulemaking Without Stakeholder Input

PVA has serious concerns that the VHA continues to develop new regulations with little to no input from external stakeholders. Some VHA workgroups are

reportedly allowing one or two veterans to participate but limited information is offered on the details. Prosthetics directives are currently being drafted and posted with virtually no notification despite PVA's insistence that the rules that impact catastrophically disabled veterans include our expertly derived and experience-based input as they are being developed (most recently, the HISA VHA 1173 directive), not as an afterthought when collegiality must necessarily give way to more adversarial means of engagement.

Focus on Underserved Veterans With MS and ALS

The need for multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS) systems of care are well documented. Unfortunately, this critical need has largely ignored by senior VHA leadership. The MS system of care directive was published but not fully implemented, particularly with regard to staffing and funding, across all of the VHA. It is inconsistently administered leaving some veterans with sub-standard care while others enjoy the full realm of rehabilitative therapies.

Meanwhile, the ALS directive was just approved after sitting on a senior VA official's desk for the past five years. It was approved without any substantive changes over that period of time. The fact that the VHA cannot get this done in a timely manner suggests a complete disregard for one of the most vulnerable populations of veterans. It is simply unacceptable that the VHA's lack of action on this issue leaves veterans with ALS with an inconsistent system.

Accredited Representative Status for VSOs

PVA believes that serious steps should be taken to strengthen accredited representative status of Congressionally chartered veterans service organizations in the VHA. While the Veterans Benefits Administration (VBA) acknowledges the role of accredited representatives pursuant to applications for VA benefits on behalf of claimants, the accredited representative power of attorney is misunderstood by senior leaders in the VHA. In cases where a veteran desires to pursue a health benefit or appeal a clinical decision, some VHA leaders will arbitrarily limit statutorily authorized access to health information by invoking Privacy Act and HIPAA shields that have no application, particularly when the veteran has explicitly authorized access to records for the purpose of pursuing benefits. This creates a system where duly appointed veterans advocates are hindered in their ability to timely address health care issues and obtain benefits on behalf of clients. It also stifles a process that would otherwise reveal systemic problems. Denying access to accredited representatives denies veteran patients an important advocate who can assist with obtaining health care services and benefits.

VA Health Care

Ultimately, PVA believes that the quality of VA health care is excellent, when it is accessible. In fact, as mentioned previously, VA patient satisfaction surveys reflect that more than 85 percent of veterans receiving care directly from the VA rate that care as excellent (a number that surpasses satisfaction in the private sector). The fact is that the most common complaint from veterans who are seeking care or who have already received care in the VA is timely access. PVA cannot deny that there are serious access problems around the country. The broad array of staff shortages that we previously mentioned in our statement naturally lead to the access problems that VA is facing across the nation. Many of the problems that the media continues to report are really access problems, not quality of care problems. While there are many detractors of the VA who would like to convince veterans and the public at large that the VA is providing poor quality care, that is simply not true. In fact, the complaints of veterans about access often ring true about health care delivery in private hospitals and clinics as well. It is no secret that wait times for appointments for specialty care in the private sector tend to be extremely long.

We believe many of the access problems facing the VA Health Care System are the responsibility of Congress and the Administration together. The Administration (and previous Administrations) has requested wholly insufficient resources to meet the ever-growing demand for health care services, while at the same time attempting to fragment the VHA health system framework. Meanwhile, it has committed to operation improvements and management efficiencies that are not adequate enough to fill the gaps in funding. Similarly, Congress has been equally responsible for this problem as it continues to provide insufficient funding through the appropriations process to meet the needs of veterans seeking care.

For many years, the co-authors of The Independent Budget—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—have advocated for sufficient funding for the VA Health Care System, and the larger VA. In recent years, our recommendations have been largely ignored by Congress. Our recommendations reflect a thorough analysis of health care utiliza-

tion in the VA and full and sufficient budget recommendations to address current and future utilization. Moreover, our recommendations are not clouded by the politics of fiscal policy. Despite the recommendations of The Independent Budget for FY 2015 (released in February of this year), the House approved earlier this year an appropriations bill for the VA that we believe is nearly \$2.0 billion short for VA health care in FY 2015 and approximately \$500 million short for FY 2016.

While we understand that significant pressure continues to be placed on federal agencies to hold down spending and Congress has moved more toward fiscal restraint in recent years, the health care of veterans outweighs those priorities. If Congress refuses to acknowledge that it has not provided sufficient resources for the VA, and that many of these access problems that are being reported around the country are a result of those decisions, then we will. Until Congress and the Administration make a serious commitment to providing sufficient resources so that adequate staffing and capacity can be established in the VA Health Care System, access will continue to be a problem.

Additionally, inadequate funding for VA infrastructure has weakened the capacity of the VA to provide care to veterans. This year the Administration requested \$561 million for Major Construction. This included funding for only four primary projects and secondary construction costs—despite a backlog of construction projects that requires a minimum of \$23 billion over the next 10 years in order to maintain adequate and serviceable infrastructure.

If the Administration refuses to properly address this construction funding problem, then we ask Congress to fill this void. There is no doubt that the new funding (approximately \$6.0 billion) requested by Secretary Gibson last week is critically needed. The Independent Budget has repeatedly expressed concerns with the woefully inadequate funding requests submitted by the Administration (and previous Administrations) and the amounts provided by Congress. Ultimately, if VA is not provided sufficient resources to address the critical infrastructure needs throughout the system, it will have no choice but to seek care options in other settings, particularly the private sector. Maintaining the capacity of the VA as a comprehensive health care provider and increasing the number of veterans seeking care within the private community is fiscally impossible. Therefore, funding VA's infrastructure needs is critical to its ability to provide safe, quality health care.

Mr. Chairman and members of the Committee, we appreciate your commitment to ensuring that veterans receive the best health care available. We also appreciate the fact that this Committee has functioned in a generally bipartisan manner over the years. Unfortunately, even veterans issues are now held hostage to political gridlock and partisan wrangling. It is time for this to stop! Political interests do not come before the needs of the men and women who have served and sacrificed for this country. We call on this Committee, Congress as a whole, and the Administration to redouble your efforts to ensure that veterans get the absolute best health care provided when they need it, not when it is convenient. PVA's members and all veterans will not stand for anything less.

This concludes my statement. I would be happy to answer any questions that you may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

National Council on Disability—Contract for Services—\$35,000.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—\$262,787.

William Carl Blake, Acting Associate Executive Director for Government Relations, Paralyzed Veterans of America, 801 18th Street NW., Washington, D.C. 20006, (202) 416-7708.

Carl Blake is the Acting Associate Executive Director for Government Relations for Paralyzed Veterans of America (PVA) at its National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of

Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia, with his wife, Venus; son, Jonathan; and daughter, Brooke.



® National Service & Legislative Headquarters
807 Maine Avenue, S.W.
Washington, D.C. 20024-2410
Phone (202) 554-3501
Fax (202) 554-3581
www.dav.org

**STATEMENT OF
JOSEPH A. VIOLANTE
DAV NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
July 24, 2014**

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

Thank you for inviting DAV to testify today about the Department of Veterans Affairs (VA) health care access crisis, the recent actions of the VA to respond to this crisis, and what changes need to be made now to ensure that veterans can access high-quality and timely health care in the future.

As the nation's largest veterans service organization comprised completely of wartime disabled veterans, DAV has an enormous stake in making certain that VA provides high-quality health care, and that it does so in a timely manner. Our 1.2 million members—all of whom were wounded, injured or made ill from their military service—regularly receive care at VA's Community-Based Outpatient Clinics (CBOCs), medical centers and other facilities. We have over three hundred National Service and Transition Service Officers who also use the VA system and nearly two hundred hospital coordinators covering every VA medical center. DAV also has thousands of Department and Chapter Service Officers and fraternal leaders who use VA, as well as a transportation network which provides more than 770,000 rides for veterans to and from VA health care facilities each year. Overall, we work directly with millions of veterans enrolled in the VA health care system and that experience informs our opinions and judgments.

Mr. Chairman, when the allegations of secret waiting lists, falsification of medical appointment records and the destruction of official documents in Phoenix, Fort Collins, Cheyenne, Austin, and other sites first came to light we were outraged; but like you, we wanted to wait for all the facts to come in before reaching final conclusions. Since then, VA's Office of Inspector General has confirmed enough information to make clear that management failures resulted in breakdowns of VA's scheduling system that left thousands of veterans without timely access to care. We continue to fully support ongoing investigations to determine exactly what happened and who is responsible for the attempts to obscure the true picture of access problems at VA facilities and whether any laws were broken. We continue to demand full accountability for those responsible for creating and continuing such flagrant violations, as well as for those who knew about them but failed to take action. Veterans and all Americans deserve to know that their government operates honestly and ethically, and when any federal employee, manager or director violates laws, regulations, rules or the public trust, they must be held accountable, no matter who or where they are in VA.

Given the serious allegations, including many that VA has already conceded occurred, we continue to recommend that outside, independent third-party auditors and investigators be brought in to ensure the objectivity and credibility of ongoing investigations, and to help regain the full trust of veterans and the American people. Further, it is imperative that VA continue to release all data, information, findings and conclusions of every internal and external investigation or audit to both Congress and the American public as soon as available.

Mr. Chairman, the breakdown in VA's management and accountability, as well as the reckless and potentially criminal actions of individuals within VA are truly shocking and absolutely unacceptable. And Congress and the Administration must work together to take appropriate steps to ensure that such management breakdowns do not occur ever again.

However, the underlying access crisis that created the waiting lists and ultimately led to these inexcusable actions was hardly shocking or unpredictable. In fact, DAV and our partners in *The Independent Budget* (IB) have been warning for years that a continual pattern of inadequate resources would lead to increased rationing and decreased access to care, and that veterans would be the ones who would be harmed.

A HISTORY OF VETERANS HEALTH CARE ACCESS PROBLEMS

As some of you may recall, a little over a decade ago, VA faced a similar and even more serious crisis over access to VA health care, as hundreds of thousands of veterans – peaking at 310,000 in July 2002 – were found to be waiting *six months or longer* just to receive primary care medical appointments. Tens of thousands more waited for specialty care.

In May 2003, a presidential task force (PTF) appointed by President George W. Bush to study how to “Improve Health Care Delivery for Our Nation's Veterans” reported the following: *“As of January 2003, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up – a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide required care.”* The PTF concluded that there was a *“mismatch in VA between demand for access and available funding...”*

This mismatch had already been confirmed when then-VA Secretary Anthony Principi in January 2003 issued regulations to reduce future demand by closing access to the VA health care system to new Priority 8 veterans. Since Secretary Principi was unable to request additional appropriations to meet the needs of all veterans seeking care at VA, he determined it necessary to limit access. Unfortunately, this mismatch would continue for most of the next decade.

One year later, at a hearing of this Committee in February 2004, Secretary Principi was asked whether VA's budget request to the Office of Management and Budget (OMB) included the full amount VA had estimated was needed, and in response he stated unequivocally, *“I asked OMB for \$1.2 billion more than I received.”*

A year later, in February 2005, the IB told Congress that, *“Access is the primary problem in veterans health care,”* and warned that *“without funding for increased clinical staff, veterans demand for health care will continue to outpace VHA's [Veterans Health Administration] ability to supply timely health care services.”*

Just a couple of months later, then-VA Secretary Jim Nicholson testified to this Committee that the Administration's FY 2005 budget would fall short and later submitted a formal request for an additional \$975 million, which Congress subsequently appropriated. Then, just weeks later, VA also requested an additional \$2 billion above what it had requested for FY 2006 earlier in the year.

Although VA's funding has increased in absolute dollars, relative to rising demand for services and rising cost of care, it was not enough and access remained a problem. In January 2008, VA reported that there were still about 110,000 veterans waiting more than 30 days for appointments, clearly illustrating what the PTF said would happen if the "mismatch" between demand and funding was not addressed.

In addition to repeatedly warning Congress about inadequate resource levels for VA health care, the IB also expressed our growing concerns that VA was not accurately or honestly measuring waiting times. In February 2010, the IB said that, *"VHA's measurement system for outpatient waiting times ... lacked credibility."*

In February 2012, the IB again told Congress that, *"...the VHA measurement system for outpatient waiting times continues to lack credibility,"* and also warned that for FY 2012, *"... the VA budget request, and ultimately the funding provided through the appropriations process, was insufficient for VA to meet the demand on the health care system."*

In December 2012, the General Accountability Office (GAO) reported long wait times for outpatient medical appointments and found that the metrics provided by VHA were "unreliable." Furthermore, GAO found that VHA's scheduling policy and training documents were "unclear" and led to inconsistent reporting of wait times.

In February 2013, the IB told Congress that, *"... the number of veterans waiting is neither publicly reported nor accessible... and should be made available on a facility-to-facility basis..."* and that, *"...this information must also be tested for validity and reliability."* We also recommended that, *"...VHA needs to improve data systems that record and manage waiting lists..."*

Once again this past February, the IB recommended that, *"VHA should make public its reports by VA facility, indicating the number of veterans [who are] waiting periods beyond the current access-to-care standards,"* and that data on waiting lists *"... must also be validated."*

The IB also warned Congress and the Administration that the VA's budget for both FY 2014 and the advance appropriations request for FY 2015 *"...will not begin to meet the projected needs of veterans already in the system and those coming to VA for the first time."*

And just two weeks ago, on July 10th, the Congressional Budget Office (CBO) issued a revised report on H.R. 3230 and estimated that, *"...under current law for 2015 and CBO's baseline projections for 2016, VA's appropriations for health care are not projected to keep pace with growth in the patient population or growth in per capita spending for health care – meaning that waiting times will tend to increase..."*

Mr. Chairman, in 1905, American philosopher and writer George Santayana famously wrote that, "*...those who cannot remember the past are condemned to repeat it.*"

The question before us today is whether we will repeat the mistakes of the past, or whether we will learn from a clear and consistent historical pattern? History shows that when VA fails to ask for full funding, or when Congress fails to provide it, the inevitable outcome is rationing of health care, decreased access and waiting lists.

That is not to say that VA's management failures did not contribute to this crisis; they did. Nor that some VA leaders, managers and employees do not need be held fully accountable for their failures; they do. There is no doubt that serious problems uncovered by this Committee, reported in the media and validated by the VA's OIG are real and must be corrected. The recent report by the White House Deputy Chief of Staff Rob Nabors' reached this same conclusion stating that VA acted, "*...with little transparency or accountability with regards to its management of the VA medical structure.*" DAV agrees.

However, the Nabors' report also concluded that the primary reason for access and scheduling problems was, "*the need for additional resources... doctors, nurses, and other health professionals; physical space; and appropriately trained administrative personnel.*" In May, the VA OIG also reported the same finding from its preliminary investigation about waiting lists, stating that, "*The highest scored single barrier or challenge was lack of provider slots...*" So if we are to prevent history from repeating, we must not only address the management problems, we must also address the resource and capacity gaps.

INADEQUATE MEDICAL CARE FUNDING FOR MORE THAN A DECADE

Mr. Chairman, over the past decade, DAV and our partners in the IB have presented testimony to this Committee and others detailing shortfalls in VA's medical care and construction budgets. In the prior ten VA budgets, the amount of funding for medical care requested by the Administration and ultimately provided to VA by Congress was more than \$7.8 billion less than what was recommended by the IB. Over just the past five years, the IB recommended \$4 billion more than VA requested or Congress approved and for next year, FY 2015, the IB has recommended over \$2 billion more than VA requested.

Even worse, the funding shortfalls that we have consistently pointed out have been exacerbated by annual budget gimmicks that replace actual dollars to be appropriated with projected savings from proposed "management efficiencies" and "operational improvements." As GAO has consistently pointed out, VA's projections of such future "savings" have rarely, if ever, been documented or substantiated, leaving VA facilities short of the funding needed to provide medical care to all veterans using the system.

For example, in a June 2011 report (GAO-11-622), GAO stated that, "*If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult trade-offs to manage within the resources provided.*" It is exactly those tradeoffs that put veterans on waiting lists.

A similar problem involves VA replacing appropriated dollars in their budget requests with anticipated collections from third party insurers. When the actual amounts collected through the Medical Care Collection Fund (MCCF) fall short of the projected levels, as has been the case almost every year, VA is once again forced to make do with less than its actuarial model estimates is needed to provide care to enrolled veterans. If just these two “gimmicks” were removed from the budgets proposed by the Administration and subsequently approved by Congress, VA would have had significantly greater resources, billions more, with which to increase staffing and better address access issues that have become so prevalent now.

Mr. Chairman, these gimmicks are well known to those who regularly examine VA’s budget submissions. For example, this Committee’s Views and Estimates letter to the Senate Budget Committee on March 2012 stated, “...*we are concerned about VA claiming savings without any real way of transparently measuring whether they, in fact, occurred.*”

Senate VA Committee Chairman Sanders expressed these same concerns in his Views and Estimates letter to the Senate Budget Committee this year, stating that “*based upon operational efficiencies identified as cost savings in previous VA budgets, I am concerned there will be a similar shortfall next fiscal year.*” He went on to express concerns about the “...*potential impact that failing to achieve the identified costs savings may have on VA’s provision of health care.*”

INFRASTRUCTURE FUNDING GAP LIMITED VETERANS’ ACCESS

The other major contributor to VA’s access crisis is the lack of physical space to examine and treat veterans seeking medical care. Over the past decade, the amount of funding requested by VA for major and minor construction, and final amount appropriated by Congress, has been more than \$9 billion less than what the IB has estimated was needed to allow VA sufficient space to deliver timely, high-quality care. Over the past five years alone, that shortfall is more than \$6.6 billion and for next year the VA budget request is more than \$2.5 billion less than the IB recommendation.

But it’s not just the IB saying this, VA’s own internal analysis confirms the size of the infrastructure funding shortfall. According to VA’s Strategic Capital Investment Plan (SCIP), which is their methodology for determining infrastructure needs, VA should invest between \$56 to \$69 billion in facility improvements over the next ten years; that would require somewhere between \$5 to \$7 billion annually. However, the Administration’s budget requests over the past four years have averaged less than \$2 billion annually for major and minor construction and for non-recurring maintenance. The fact that VA has consistently requested less infrastructure funding than actually needed is also well known to those who regularly examine VA’s budget and appropriations requests.

Mr. Chairman, we appreciated the attention given to the VA infrastructure shortfall in the Committee’s Views and Estimates letter from March 2012, in which you stated that, “*We believe that the Administration failed to request sufficient funding for non-recurring maintenance...*” Similarly, we appreciated you raising the infrastructure issue with former Secretary Shinseki again last year, when you referenced the IB’s testimony regarding the \$25 billion major construction backlog, pointing out that the Administration’s FY 2014 budget plan proposed,

"...\$342 million for major construction, putting us on a course, I believe, for completion of all projects in 70 years."

And earlier this year at a Senate Appropriations Subcommittee hearing, Senator Tim Johnson stated what almost everyone in the room already knew about VA's inadequate infrastructure request:

Quality VA medical care cannot be provided in substandard facilities, and yet the VA's investment in major and minor construction and non-recurring maintenance is woefully inadequate and falling further behind every year. If these shortfalls are not addressed soon, patient care will suffer.

Unfortunately, neither the House nor the Senate ultimately took any actions to significantly increase funding in recent years for VA's construction and facility maintenance accounts above the Administration's inadequate requests, ignoring not just the IB's recommendations, but VA's internal SCIP analysis. This failure to build, maintain and replace VA's hospitals and clinics limits the space in which veterans can be treated and as we have seen, directly impacts the timeliness and quality of care. For example, in Phoenix, where the whistle was first blown on the falsification of wait times, they have been waiting for years to open a new outpatient clinic to handle the rapid growth in veteran patients. However, due to insufficient total appropriations provided for VA's infrastructure over the past decade, the Phoenix clinic has been forced to wait years in the funding queue, only reaching the top this budget cycle, a day late and a dollar short.

Mr. Chairman, the debate over whether there is a mismatch between demand for VA health care services and the resources provided to VA is a settled issue. Not only is the historical record clear, why else would the House vote 426-0 and the Senate vote 93-3 for legislation to expand veterans' access to health care that CBO estimated could cost at least \$30 billion in the first two years, and up to \$54 billion annually after that, if there was already enough money? So the only question that remains is when, where and how new resources should be directed in order to most effectively increase veterans' access to health care in the short term and in the long term.

CONGRESSIONAL RESPONSE TO VETERANS' ACCESS CRISIS

In June, both the House and Senate passed legislation to dramatically expand the provision of non-VA care to veterans, however there are significant differences between the two bills in terms of when such care is authorized, how it is coordinated, and how it would be scored and paid for by the federal government. There are also questions over how non-VA providers will integrate their medical records into VA's electronic health record system so that there is seamless record keeping to ensure integrated care and patient safety? And even if VA has the resources to pay for non-VA care, are there sufficient, qualified health care professionals available in every community to provide such care? Simply giving a veteran a plastic card and wishing them good luck in the private sector is no substitute for a fully coordinated system of health care.

Currently, a House-Senate Conference Committee is meeting to examine these questions and develop a compromise. However, since most of the work of the Conference Committee is

not done in open sessions, DAV and 19 other leading veterans and military service organizations wrote to the conferees on June 17th to put forward a series of comments that reflected our shared view of what needed to be accomplished. Although we all have different missions, memberships and perspectives on the best path forward, we all shared one overriding principle: *"...no veteran who is eligible for VA health care should be forced to wait too long or travel too far to get medical treatment and services they have earned..."*

In our united view, the first priority for Congress and VA *"...must be to ensure that all veterans currently waiting for treatment ...are provided access to timely, convenient health care as quickly as medically indicated."* Second, we all agreed that when VA is unable to provide the care in VA facilities, *"...VA must be involved in the timely coordination of and fully responsible for the payment for all authorized non-VA care."* Third, we stated that supplemental funding for this year and additional funding for next year must be provided to pay for the temporary expansion of non-VA purchased care. Further, Congress and VA must not rely on the typical budgetary gimmicks, such as "management efficiencies", whose use in the past directly contributed to the current crisis.

Finally, all of the VSOs and MSOs agreed that whatever actions VA or Congress takes to address the current access problems must *"...protect, preserve and strengthen the VA health care system so that it remains capable of providing a full continuum of high-quality, timely health care to all enrolled veterans."* We cautioned that if Congress intends to create a two-year program to expand non-VA care, it must also simultaneously take the necessary actions to *"...strengthen VA health care delivery, expand access and capacity, reallocate resources and ensure that overall VA funding matches its mission."*

These are the standards a united veterans community laid out for Congress one month ago as you considered how to respond to the access crisis. Although the Conference Committee has not yet reached a compromise, VA has taken some significant actions to address this crisis.

VA PROPOSAL TO EXPAND HEALTH CARE ACCESS

Last week, Acting Secretary Sloan Gibson testified before the Senate Veterans' Affairs Committee about the progress made over the past two months in addressing health care access problems. According to Secretary Gibson, the VHA has already reached out to over 160,000 veterans to get them off wait lists and into clinics. VHA accomplished this by adding more clinic hours, aggressively recruiting to fill physician vacancies, deploying mobile medical units, using temporary staffing resources, and expanding the use of private sector care. Gibson also testified that VHA made over 543,000 referrals for veterans to receive non-VA care in the private sector – 91,000 more than in the comparable period a year ago. In a VA press release, VA stated that it had reduced the New Enrollee Appointment Report (NEAR) from its peak of 46,000 on June 1, 2014 to 2,000 as of July 1, 2014, and that there was also a reduction of over 17,000 Veterans on the Electronic Waiting List since May 15, 2014.

Secretary Gibson testified that after re-examining its resources needs in light of the revelations of secret waiting lists and hidden demand, VA was requesting supplemental resources totaling \$17.6 billion to be spent over the remainder of this fiscal year through the end

of FY 2017. This supplemental funding would average between \$5 billion to \$6 billion per fiscal year, significantly less than what either the House or Senate proposal is estimated to cost.

The majority of this new funding, approximately \$8.1 billion, would be used to expand access to VA health care over the next three fiscal years by hiring up to 10,000 new clinical staff, including 1,500 new doctors, nurses and other direct care providers. That funding would also be used to cover the cost of expanded non-VA purchased care, with the focus shifting over the three years from non-VA purchased care to VA-provided care as internal capacity increased. The next biggest portion would be \$6 billion for VA's physical infrastructure, which according to Secretary Gibson would include 77 lease projects for outpatient clinics that would add about 2 million square feet, as well as 8 major construction projects and 700 minor construction and non-recurring maintenance projects that together could add roughly 4 million appointment slots at VA facilities. The remainder of the VA supplemental request would go to information technology enhancements, including scheduling, purchased care and project coordination systems, as well as a modest increase of \$400 million for additional VBA staff to address the claims and appeals backlogs.

Mr. Chairman, comparing this supplemental funding request to the historical funding shortfalls identified by the IB, and taking into account the progress achieved by VA over the past two months and the questions about legislative proposals under consideration by the Conference Committee, we are convinced that the request by Secretary Gibson is a reasonable and intelligent way to expand access now, while building capacity to avoid future access crises in the future. Unlike the proposals in the Conference Committee, the VA proposal would have an immediate impact on increasing access to care for veterans today by building upon VA's expanded access initiatives underway and sustaining them over the next three years. Furthermore, by investing in new staffing and treatment space, VA would be able to continue providing this expanded level of care internally, even while increasing its use of purchased care when and where it is needed.

By contrast, the House and Senate bills would take significant time to be implemented and would not create permanent new capacity. There are also significant questions regarding care coordination, provider reimbursement and overall costs of the contracting-out programs envisioned by the House and Senate proposals. Given the massive scale of what those bills propose, upwards of \$50 billion annually if continued in future years according to CBO, it seems like a reasonable and responsible investment to spend less than \$6 billion each of the next three years, particularly since it would create permanent new capacity to treat veterans in the VA system. The fact that both bills being considered in the Conference Committee have sunset provisions approximately two years from enactment also raises a very serious question about how the increased demand created through generous private health care programs will be met once that authority ends. If VA doesn't have the capacity today to meet its current demand, and the facts prove they don't, how will VA be able to meet significantly increased demand in the future unless smart investments in the VA system are made today?

IMPORTANCE OF SUSTAINING THE VA HEALTH CARE SYSTEM

Mr. Chairman, we greatly appreciate your clear statements that you want to fix, not get rid of the VA health care system. However, it has become evident that the current crisis has become an opportunity for some to push an ideological agenda to dramatically shrink or

eliminate the VA health care system. In fact just last week, at a think tank event that you were scheduled to speak at, one of the so-called experts said that in his view the current access crisis proves that VA should be eliminated altogether, and that veterans should simply be given vouchers or cards to fend for themselves in the private sector. We could not disagree more strongly.

In our view the VA health care system is both indispensable and irreplaceable; there is no substitute for it. Based upon our collective knowledge and experience, we continue to believe that veterans are now and will be better served in the future by a robust VA health care system than by any other model of care. While there are both serious access and management problems that must be corrected, the VA health care system is an essential part of America's health care system. VA today operates nearly 1,700 sites of care including 152 hospitals, almost 900 community-based and mobile outpatient clinics, 300 Vet Centers for psychological counseling and other facilities that provide vital health care and services to millions of veterans. VA provides medical services to more than 6 million veterans annually, out of almost 9 million enrolled in the VA system.

In addition, VA's clinical research program has elevated the American standard of care and invented cutting edge devices and treatment techniques that have improved the lives of millions of veterans and non-veterans in areas such as spinal cord injury, blind rehabilitation, amputation care, advanced rehabilitation (such as polytrauma and traumatic brain injury), prosthetics, post-traumatic stress disorder, substance-use disorder, multiple sclerosis, diabetes, Alzheimer's, Parkinson's and dementia.

It is also worth noting that in addition to providing high-quality health care to veterans, VA is also the largest single provider of health professional training in the world. Each academic year, VA helps train over 100,000 students in the health professions through its academic affiliation with 152 schools of medicine and over 1,800 schools in total.

DEBUNKING MYTHS ABOUT VA HEALTH CARE

Unfortunately, while there has been much good reporting on the problems in the VA health care system, there has also been a tremendous amount of false and distorted information in the media, much of it repeated by some in Congress. For example, some Members of Congress have stated that VA funding rose over 250 percent during the past decade while the number of veterans has dropped from about 25 million to just over 21 million, thereby concluding that the VA health care system is overfunded and highly inefficient. While those numbers individually are accurate, linking them together creates a highly misleading inference. The reality is that most of the increase in VA's overall budget goes to mandatory benefits, such as disability compensation and G.I. Bill education payments, not to the health care system. VA health care funding has grown from \$33.5 billion to \$55.1 billion in real dollars, a 64 percent increase over the past decade, however there are more, not fewer, veterans in the health care system, contrary to assertions by some. The number of veterans treated by VA rose 39 percent but most importantly, utilization increased by 95 percent, as outpatient visits nearly doubled from 46.9 million in 2002 to 91.7 million in 2013. In addition, the complexity and cost of specialized care for traumatic brain injury, prosthetics, burns and other wounds of war has risen significantly, further straining VA's ability to deliver timely, high-quality health care to enrolled veterans.

Another false argument being made by some is that since VA carries over unobligated funding from one year to the next, \$500 million or more per year, the cumulative total would be the sum of each year's individual total. Using this logic, they argue that VA received about \$4.5 billion more in appropriations than was needed during that timeframe, and then assert that this proves VA is flush with cash and that "money is not an issue."

However, as can be demonstrated easily, carryover funding is subtracted from, not added to, the budget request for the next fiscal year. Carryover funding is not extra funding for the next fiscal year, rather it is forwarded into and becomes part of the next year's budget, and therefore the request for future appropriations is reduced by the amount of the expected carryover. It is mathematically incorrect to add each year's carryover and use that cumulative total, since each year's carryover of "unobligated" balances is no longer "unobligated" once it is carried over; at that point it becomes part of the next year's baseline budget.

The correct way to determine the cumulative total of "unobligated" funding is to look at the most recent carryover total, which is the true amount of "unobligated" funding over any time period. It is no different than a simple checking account. If you have a \$500 balance in your account at the end of the year that is similar to "unobligated" funding. If you maintain a \$500 balance for five straight years, you do not add them together and conclude that you now have \$2,500 of "unobligated" funding in your account; you still only have a \$500 balance. Since this year's VA budget was projected to carry over approximately \$450 million into next year, the cumulative total of carryover for the past five years would actually be \$450 million, not \$4.5 billion as some have alleged. Furthermore, since VA is now projecting to spend the entire carryover balance this year, the actual cumulative total of "unobligated" funding over the past five years will be zero.

Mr. Chairman, for some the use of carryover is a new issue; however, as you know, this is hardly a revelation to those who oversee VA's budget. As this Committee stated in its Views and Estimates letter of March 18, 2011, "*...we agree that carryover of funds from one year to the next is a prudent use of taxpayer dollars and must absolutely be built into a subsequent year's budget request... Again, we agree that permitting VA to carry money over into a subsequent fiscal year is, and always has been, an important aspect of how VA manages its resources effectively.*"

We also agree that carrying over "unobligated" funds is good fiscal management when there was no need to use that funding to provide health care access to veterans. Too often, however, VA has used "carryover" as a budget gimmick to ration access to care while reducing the need for future appropriations requests. When there is excess demand compared to available resources, as we argue has been the situation for most of the past two decades, VA must use any "unobligated" funding to meet that demand, not carry it over to the next fiscal year.

Another highly misleading statistic is the number of adverse incidents in VA hospitals that result in or contribute to patient deaths. For example, a story by the *Washington Free Beacon* last week reported that there were more than 500 such adverse incidents at VA hospitals last year, which would give the impression that the VA health care system is unsafe and certainly

less safe than private sector health care systems. However, the story fails to put this into any reasonable or rational context of modern American medicine.

According to a *Scientific American* article from September 2013, the number of people who die due to mistakes made in U.S. hospitals every year ranges from a low end estimate of approximately 100,000 to a high end estimate of up to 440,000. So how does VA compare to all other private hospitals in the US? Since there are approximately 150 VA hospitals, that would mean that there were between 3 and 4 preventable deaths per VA hospital last year. By contrast, there are approximately 5,000 private hospitals in the U.S., which would mean that there were between 20 and 100 preventable deaths per private hospital last year. That's a much different story than the one regularly being reported by the media. I would note, Mr. Chairman, that you did attempt to add some balance to that story by pointing out that, "*Like other hospital systems, VA isn't immune from human error—even fatal human error.*"

To be clear, we do not accept nor condone a single preventable death of a veteran in a VA hospital, but no health care system is perfect, and medicine is far from an exact science. When grievous medical errors result in patient harm or death, VA must act swiftly, transparently and effectively to identify and correct problems when they arise. However the distortion of facts and the manipulation of statistics by some to justify a crusade to eliminate the VA health care system is outrageous. If we are to respond to the current crisis and prevent it from recurring in the future, we must have an open and honest debate about both the causes of the access problems and the effects of the proposed solutions.

For more than a decade, DAV and our partners in the IB have been telling Congress and the Administration that the funding provided to VA was inadequate to meet current and future health care needs of veterans. We warned that a lack of sufficient health care resources, particularly clinical staffing and infrastructure, would lead to rationed care, diminished access and waiting lists. Sadly, history has proven us correct.

Given all that has transpired over the past few months, and considering the size and estimated costs of the legislation being considered by Congress to address this crisis, there can be no debate that the mismatch identified more than a decade ago continues today. Now it is up to Congress and the Administration to take the steps necessary to end the mismatch, provide VA the resources it needs, and work together with VSO stakeholders to strengthen the VA health care system now and in the future so that enrolled veterans receive high-quality, timely and convenient medical care.

That concludes my testimony and I would be happy to respond to any questions you or the Committee may have.

Vietnam Veterans of America



Presented by

Richard Weidman

Executive Director for Policy & Government Affairs

BEFORE THE

House Veterans Affairs Committee

REGARDING

**Restoring Trust: The View of the Acting Secretary and the
Veterans Community**

July 24, 2014

Vietnam Veterans of America**House Veterans Affairs Committee
July 24, 2014**

Good morning, Chairman Miller, Ranking Member Michaud, and distinguished Members of the House Veterans Affairs Committee. On behalf of VVA National President John Rowan and all of our officers and members, we thank you for the opportunity for Vietnam Veterans of America (VVA) to share our views regarding "Restoring Trust: The View of the Acting Secretary and the Veterans Community." I ask that you enter our full statement in the record, and I will briefly summarize the most important points.

VVA thanks the Committee for the tenacious and bi-partisan pursuit of the truth as to what was really happening at VA over the past several years. The shortage of clinicians that leads to "gaming the scheduling system" is not just a problem the Phoenix VAMC, nor is it just at the other 26 VA Medical Centers (VAMC) reported in the press. It is in fact the case at virtually every Veterans Health Administration's (VHA) service delivery point, both VAMC and the satellite Community Based Outreach Clinics (CBOCs), and the free standing Outpatient Clinics (OPC).

Acting Secretary Gibson has eliminated the perverse rewards system that in effect rewarded people for lying. It appears that he is committed to rooting out those who have lied, and sending them off to seek other opportunities outside the VA, which VVA strongly supports.

Truth in reporting allows for true identification of problems areas, and leads to a timely address and the initiation of corrective actions. This then leads to data that provides information on outcomes of the actions taken. This may be the real road to performance reviews. Without truth there will be no faith in either the VA's numbers, or anything they say in the future.

VVA has been saying for a decade that some VA officials were coming into this hearing room and not tussling the truth. Hopefully, that dark chapter is now almost over.

We do not understand why there has been no re-deployment all VHA staff that have clinical credentials and training, but are currently in a non-direct services provider position, to serve at least 4 days per week in provision of direct clinical care.

VVA also continues to urge that all VHA administrative staff, especially those on VISN staff with non-clinical credentials, to be detailed to work directly with clinical care providers to assist in the delivery of direct clinical care by taking the administrative load off of clinicians. This would include assisting veterans who cannot be seen in a timely manner by a VA clinician to secure timely care utilizing the fee for service program with a private provider.

VVA continues to urge the Acting Undersecretary and the Acting Secretary to work to bring to national scale the “Grow Our Own” program to train clinicians and allied health care professionals, as well as physicians and other clinicians. These veterans would have to work for VA for two years for every year of education provided by VA or pay back the cost of their education. (See appendix)

Further reductions in overhead can be achieved by consolidating the current “policy” chain of command with the “operations” chain of command that currently exist in both VHA and in the Veterans Benefits Administrations’ Compensation & Pension Service. We need more direct service providers, we need more claims adjudicators. We do not need more administrators who “pass the buck” between sections/divisions over a veterans’ clinical care or treatment program.

VVA also continues to recommend that they direct every VAMC to set up special screening units to be set up and operational within six months to screen veterans for the major “killers” and most prevalent diseases. These units should screen *ALL* veterans who are waiting for initial care (not just those who are already service connected compensable veterans) to test for the leading causes of morbidity/mortality among veterans in the VHA system. These would include but not be limited to: mental health (i.e., suicide), heart disease, hepatitis (particularly Hepatitis C), lung cancer, prostate cancer, bladder cancer, colo-rectal cancer, leukemia, skin cancer, and other leading killers of veterans. Those who test positive for any of these conditions should be seen by a VA clinician within just days, not weeks. If there is not the VA staff to meet any such immediate need, then the veteran shall be assisted to secure such services of an outside clinician immediately, through the active assistance of VA staff, and to do so in a matter of days. This would dramatically reduce in-patient stays and early morbidity in the relatively near future.

For the immediate future, VA must junk the “Millman formula” in estimating clinical needs because it will *always* underestimate the clinical needs of *veterans* at a geometrically accelerating pace over a series of years. This is because it is a *civilian* formula that does not take into account the special health care needs of military veterans. Develop a formula that takes into account the wounds, illnesses, maladies, diseases, and adverse medical conditions or risks that result from military service.

The VHA temporary leadership, for the first time in more than a decade, is taking seriously the vital need to program every veterans’ military history into each veterans’ permanent VistA electronic health record, including branch of service, when and where each veteran served, and their MOS on each veterans’ VistA electronic health record, so that it is keyed to electronic clinical reminders to the VA providers of care who see such veteran. For reference, see: <http://www.va.gov/OAA/pocketcard/> and: <http://www.publichealth.va.gov/exposures/providers/index.asp>

There is actually a rough outline as to how they will do this, for the first time. We need to keep the pressure on in order to see that it actually does get done.

The cooperation and positive attitude of the Acting Secretary of Health Carolyn Clancy is just really refreshing. Discussions with both she and Dr. Madhulka Agarwal, head of Patient Care Services has brought more progress in the last few weeks, and a new attitude that will result in a much stronger VHA.

They are interested in pursuing the suggestion that VHA mandate that every VA primary care clinician take the Continuing Medical Education (CME) courses regarding medical conditions that may affect veterans as a result of exposures or incidents in their military service, from parasites to cold injuries to toxic exposures to caring for combat wounds. This should be tracked, and should be tied to their annual evaluations. (It is known as the Veterans Health Initiative or www.va.gov/vhi)

VVA has said to VA officials, including the Acting Secretary that VA should seek an emergency supplemental appropriation of “two year” money of what we estimated almost two months ago should amount of at least \$2.5 billion that would be used for direct clinical care only. Most of it should go toward hiring more clinical services providers on a permanent basis at VAMC, and some of it should be used to pay for the “fee basis” services secured until VAMC adds the permanent capacity to deliver such needed care in a timely fashion, but which is not now immediately available. That figure may be low, but it is probably as good as any estimate that can be derived before there is a system in place to deliver numbers we can have confidence in as being more or less accurate.

VVA also believes that there needs to be an emergency supplemental appropriation of “two year” money in the amount of \$900 million to \$1.5 Billion to be used for reconfiguring now unused space at VAMCs for delivering care in short order, or to reconfigure current clinic physical facilities to maximize each clinicians time, thereby allowing for increases in panel size with no diminishment of quality.

It appears clear to us that the new Secretary and the Deputy Secretary will not tolerate any manager or supervisor that takes, or causes to be taken, any sort of retaliatory action against any VA employee who shares the truth with anyone outside of the VAMC or CBOC or OPC or VA. We think it is clear that such acts will result in immediate suspension, followed by proceedings for separation from employment, to include possible loss of retirement benefits.

The Acting Secretary has mandated each VAMC will meet monthly with the major service organizations to discuss policies, staffing levels, funding streams, problems, and to foster more cooperation. These meetings should involve no more than 10 or 12 veteran/military service representatives (VSO/MSO), with significant VSO input into the agenda. In addition, each VAMC should have at least one mass briefing or town hall open to any veteran at least once per year, but they would be start to do so quarterly. VSO/MSO must have meaningful input to the agenda for each such meeting

Real Leadership

Many in the media are very skeptical that the House and Senate, and the two parties can come together to provide the leadership of Congress, both Republican and Democratic, as well as Congressional authorizers and appropriators on both sides of the aisle, that will cooperate with the Executive branch in meeting this crisis. VVA is not pessimistic, but rather optimistic that there will be a workable deal, and that there will be honest collaboration in rebuilding the VA.

We do think that the Committees and the Secretary should seek the help and cooperation of medical schools & colleges, as well as all of the major clinical specialty societies and disease advocacy groups, to assist in the effort to secure more clinicians to work at VA now and into the future.

Seek the cooperation and assistance of other major institutions in our society, such as the Chambers of Congress, small business groups and associations, the Masons, the Elks, Kiwanis, the Rotary Clubs, etc. as well as the faith-based service groups to secure their assistance, particularly in rural areas. Many of these organizations are already quietly helping veterans in their community, but would be willing to do much more if asked.

When the chips are down, America has always responded, and the chips are now down for America's veterans.

I would be pleased to answer any questions you may have, Mr. Chairman

Vietnam Veterans of America

House Veterans Affairs Committee
July 24, 2014**VIETNAM VETERANS OF AMERICA****Funding Statement**

July 24, 2014

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

Executive Director of Policy and Government Affairs
Vietnam Veterans of America
(301) 585-4000, extension 127

Richard F. Weidman

Richard F. “Rick” Weidman is Executive Director for Policy and Government Affairs on the National Staff of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo as statewide director of veterans’ employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor’s Advisory Committee on Veterans Employment & Training, the President’s Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on Veterans’ Entrepreneurship at the Small Business Administration, and numerous other advocacy posts. He currently serves as Chairman of the Task Force for Veterans’ Entrepreneurship, which has become the principal collective voice for veteran and disabled veteran small-business owners.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., 1967), and did graduate study at the University of Vermont. He is married and has four children.

Vietnam Veterans of America

House Veterans Affairs Committee
July 24, 2014

Attachments

Department of Veterans Affairs

Memorandum

Date: 19 FEB 2014

From: Grow Our Own ICT advancement program Project Team Leader

To: Mr. Sullivan, Director, and CAPT Jose A. Acosta, Commanding Officer/Deputy
Director,
CAPT. James A. Lovell Federal Health Care Center, North Chicago, IL 60088

Subj: GROW OUR OWN PROGRAM UPDATE

1. Two Intermediate Care Technicians have been identified as potential Grow Our Own PA program candidates to date. The transcripts of these two candidates have been submitted to the Rosalind Franklin PA program. Rosalind Franklin has responded with a potential timeline to graduation as a PA based on the transcripts that the two candidates currently have and the length of time that it would take them to attain the pre-requisites to be accepted into the Rosalind Franklin PA program. The suggested timeline is premised in the candidates continued enrollment in a college level classes pursuing their pre-requisites and fulltime classroom/clinical enrollment while attending the tow years of actual PA school.
2. Mr. Joseph Carney, an ICT here in FHCC Emergency Department, needs 50 credit hours to qualify for acceptance to the PA program. A reasonable time frame to expect him to complete these requirements is 1.5 years, followed by the two year PA program. Following this timeline Mr. Carney should be able to finish his pre-requisites and Bachelor degree by December 2015. He would be eligible for the PA program convening in June 2016. He would graduate as a PA in June 2018.
3. Mr. Richard Baca is an ICT in the New Mexico VA Hospital. Mr. Baca needs an additional 90 hours to complete his BS pre-requisite. Mr. Baca should be able to finish his program requirements by January 2017. He would be able to start the PA program in June 2017. He would graduate as a PA in June 2019.
4. Three additional ICT's have contacted program representatives and expressed an interest in the Grow Our Own program. Once their college transcripts have been received by program representatives and reviewed by our program's participating schools, a prospective timeline will be created for them. The Grow Our Own project

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leader will be contacting each ICT that has not already contacted the program to identify other potential candidates that are currently unaware of our ICT to PA pathway initiative.

5. In order to meet the program requirements and estimated timelines the students will be required to enroll in pre-requisite classes as each required class becomes available, in a reasonable timeframe, and to maintain a grade of at least a C.

6. ICT's enrolling in the Grow Our Own PA pathway are eligible for VA National Education for Employees Program (VANEED). If approved for participation in VANEED the ICT will retain salary while attending school. Healthcare Talent Management, the VACO administrators of VANEED, pays tuition, fees, books, and provides the facility with salary replacement. Note: Salary replacement does not pay the participant's salary, it is used to bring in a replacement or pay overtime (facility discretion).

7. For additional information on the progress and status of the Grow Our Own program, please contact the Grow Our Own Project Team Leader, Mr. David Lash, at 847-688-6755, X89451 or david.lash@med.navy.mil.

Sincerely,

D. J. Lash



Statement of Iraq & Afghanistan Veterans Of America
before the
House Committee on Veterans' Affairs
for the hearing on
**Restoring Trust: The Views of the Acting Secretary and the
Veterans Community**
July 24, 2014

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the Committee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), thank you for the opportunity to share with you our views and recommendations on what changes should be made to reform the Department of Veteran Affairs (VA) and on VA communication and collaboration with veteran service and advocacy organizations.

As the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan, IAVA's mission is critically important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we aim to help create a society that honors and supports veterans of all generations.

In recent months, revelations about extensive patient wait times, manipulation of data, a systemic lack of accountability, and even preventable veteran deaths within the VA system have undermined the trust of the American public in our VA, and it has had a particular impact on the trust and confidence of IAVA's members. While it is true that many of our members have expressed general satisfaction with the quality and delivery of the health care they receive from the VA, many have also expressed serious frustration with general access to and direct communication with the VA.



Statement of Iraq & Afghanistan Veterans of America
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On July 10th of this year, when Mrs. Susan Selke, the mother of deceased Marine Corps veteran Clay Hunt, testified before this Committee about the tragic experience of losing her son to suicide, one of the most heartbreaking aspects of her testimony and of Clay's story was the consistent inability for Clay to receive proper care from VA facilities in Los Angeles, California, Grand Junction, Colorado and finally in Houston, Texas. Mrs. Selke testified that Clay not only encountered significant difficulties in scheduling visits with psychiatrists and mental health professionals, but also with the inability of the VA to continue treating Clay with the same medications on which he had been successfully treated while on active duty and with the guinea pig-style treatment he felt he was receiving throughout his VA experience.

We know of issues like these largely from anecdotal evidence, through testimony from brave individuals like Mr. and Mrs. Selke and Dr. and Mrs. Somers, and through the revelations that have come out of both media and this Committee's investigations. And we know of them from countless reports and stories from our members, like Clay.

The issues our members have had with scheduling certainly are problematic, but they are not the only problems they face as they seek care at the VA. Our members have also shared with us significant problems concerning over-medication for conditions such as post-traumatic stress, depression, and issues related to traumatic brain injury.

When Clay finally arrived at his appointment with a psychiatrist, the counseling he received consisted of a quick conversation about how his current medication was impacting his symptoms. If one didn't seem to work well enough, he'd be switched to another, and another, and another, each with its own adjustment and uptake period and unique set of side effects. As this Committee is well aware, Mr. Chairman, the Center for Investigative Reporting found that over the last 12 years, there has been a 270 percent increase in Veterans Health Administration (VHA) prescriptions for four powerful opiates.¹ In addition to pain medications, psychiatric medications have been prescribed at alarming rates as well.²

¹ Glantz, A. (2013, September 28). VA's opiate overload feeds veterans' addictions, overdose death. *Center for Investigative Reporting*. Retrieved from <http://cironline.org/node/5261>

² Government Accountability Office. (2012, November 14). DOD and VA Healthcare: Medication Needs during Transitions May Not Be Managed for All Servicemembers. Retrieved from <http://www.gao.gov/products/GAO-13-26>



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These empirical findings comport with IAVA's anecdotal findings based on member reports, complaints, and stories. Indeed, over medication has taken its toll on our membership. One IAVA family member last year expressed frustration that her husband was prescribed nine different medications to address a range of health issues related to pain, anxiety, and depression. He tragically passed away from what was labeled an accidental overdose by the coroner, and his widow has been fighting to have the reality of overmedication by the VA documented in his treatment records.

IAVA is pleased to see some recent changes within the Veteran Health Administration, but we are eager to see more structural reforms pursued in the areas of accountability, the adoption of technology, and increased capacity to deal with future needs. Congress acted swiftly in the area of accountability in response to the system-wide VA scheduling scandal by passing the VA Management Accountability Act. We are pleased to see this piece of legislation move forward, but our members want to ensure that the Secretary of the VA actually uses it once it is signed into law in order to clean out the organization of negligent or inefficient top-level bureaucrats. We would even welcome the extension and application of a similar authority to Title 38 and GS employees within the VA as well.

IAVA would also like to see the VA adopt not only new, more user-friendly technological platforms, especially those that are veteran-facing, but we believe the organization needs to begin a shift in the way it looks at its technology needs and how it goes about acquiring and/or designing those systems. Compared to private-sector user interfaces, the VA's web-based platforms and portals are, frankly, a joke to many Iraq and Afghanistan-era veterans. With respect to the VA's internal scheduling software in particular, the average age of most of the members of our organization is younger than the scheduling system currently in place at VHA. We believe that an updated system should include a much more robust user experience that will improve efficiency for VA staff and convenience for veterans who interact with VHA.

Finally, our members want to see an increase in the VA's capacity to deliver critical services to veterans, especially in the realm of mental health care. The shortage of psychologists, psychiatrists, counselors, case and social workers, and other mental health professionals and service and support staff must be remedied quickly. Additionally, there needs to be continuity of not only medical records, but also medical care and medication availability between DOD and VA, and more evaluation of and cooperation among the myriad programs already in existence to help combat suicide and the effects of invisible injuries among troops and veterans. Many of these reforms are included in the Clay Hunt



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Suicide Prevention for America's Veterans (SAV) Act, and IAVA members are expecting the Committee and the full House to pass this critical legislation before the election.

Some of these and many other reforms are actions that the VA could have pursued, at least partially, all along. Unfortunately, the VA's level of communication, cooperation, and collaboration with new-generation organizations - like IAVA - over the past 5 years has been severely lacking. In fact, prior to the outbreak of the current VA access scandal, the former Secretary of Veterans Affairs had only met with IAVA directly on one occasion during his entire tenure as Secretary. Much like the VA's attitude toward this Committee, if the prior regime within VA did not like what they were hearing from its nonprofit partners, or if those partners refused to tow the party line, they were shut out entirely from top-level access.

IAVA paid that price for years in exchange for standing up, speaking out, and conveying the truth of the situation at VA that our members were communicating to us. And like this Committee and the red flags it began raising about serious issues years ago - from delayed GI bill payments to the backlog to obscene patient wait times - we turned out to be right and are proud to have held our ground and faithfully advocated for our members.

VA's interim leadership, however, has been much more communicative and cooperative, and the new VSO liaison VA brought on board immediately before the access crisis broke has done a phenomenal job at working to repair the relationship between the VA and the nation's largest organization of Iraq and Afghanistan veterans and their families.

Although we were not consulted by the White House on the choice of Mr. Bob McDonald to be the new Secretary of Veterans Affairs, we are thankful that he proactively reached out to us following his nomination announcement. We are very eager to get to know Mr. McDonald better and look forward to having a communicative and strong working relationship with him and his senior staff in the future.

In addition to the above, we also want to take this opportunity to let Members of the Committee know that today IAVA is releasing the results of its 2014 member survey at the National Press Club. IAVA's policies, positions, and priorities are driven every year by our annual member survey, and the data this year overwhelmingly reveal that suicide and mental health care access at the VA are the top challenges facing this generation of veterans.



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More information about the results of our member survey will be available today at iava.org, and our staff research team, led by Dr. Jackie Maffuci, would be happy to brief you and your staff on our detailed 2014 findings in the very near future.

Mr. Chairman, we again appreciate the opportunity to offer our views on these important topics, and we look forward to continuing to work with each of you, your staff, and this Committee to improve the lives of veterans and their families.

Thank you.